MARYLAND HEALTH CARE COMMISSION

Required Under SB 477 (2003)
Small Business Health Insurance Affordability Act

Study of Issues Related to the Small Group Market:

Administrative Costs of Health Plans
Methodology for Developing the Comprehensive Standard Health Benefit Plan
Report on the Feasibility of a Basic Plan
Other Potential Changes to the Small Group Market

January 1, 2004

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Study of Issues Related to the Small Group Market

In 1993, the Maryland General Assembly enacted legislation regulating the sale of health benefits by insurers and health maintenance organizations (HMOs) to small businesses in the State. The reforms apply to all contracts issued or renewed after July 1, 1994, and include guaranteed issue and renewal, adjusted community rating with bands, and elimination of pre-existing condition limitations. Further, the insurance law requires carriers in the small group market to sell only the Comprehensive Standard Health Benefit Plan (CSHBP). Carriers may sell additional benefits through riders but these enhancements must be offered and priced separately.

The Maryland Insurance Administration (MIA) and the Maryland Health Care Commission (MHCC or Commission) have joint responsibility for administering these reforms. The MIA must approve contracts, rates, and forms, as well as monitor carrier marketing. MHCC is responsible for the design and annual review of the CSHBP.

By statute, the CSHBP must include benefits that are at least the actuarial equivalent of the benefits required to be offered by a federally qualified HMO. The CSHBP must have uniform cost sharing arrangements. Initially, the average premium for the standard plan could not exceed 12 percent of Maryland's average annual wage. The 2003 General Assembly lowered this affordability cap to 10 percent. If the Commission finds the average rate for the standard benefit plan across all carriers and delivery systems exceeds or is projected to exceed 10 percent of Maryland's average annual wage, the MHCC must modify the CSHBP by increasing the cost sharing arrangements or decreasing benefits.[1] Carriers pool the risk of all small groups they regulate - the rate charged to any particular employer group cannot vary by more than ±40% from the average rate.

Since the Commission designs the CSHBP, it must monitor certain aspects of Maryland's small group health insurance market. First, the MHCC must calculate the average cost of the CSHBP to ensure that the plan remains under the statutory ceiling. Second, the MHCC must monitor fluctuations in the number of lives covered or the number of contracts written in the small group market. If these numbers decrease substantially in any given year, the MHCC may need to carefully examine the CSHBP to determine if it is meeting the needs of Maryland's small employers and their employees. Finally, specific premium data allow the MHCC to predict more accurately the impact of any proposed changes on the average rate of the plan.

Overview of Current Experience with the Small Group Market

In the spring of 2003, Commission staff collected financial information from all carriers participating in the small group market during calendar year 2002. The following presents information based on the data collected:

[1] The 10 percent income affordability cap is projected to be exceeded in calendar years 2003 and 2004. Discussions later in this report cover in detail recommendations to conform to the cap.

Current Method for Calculating the Affordability Cap – *Average Wage and Average Cost, Excluding Riders* 10% Affordability Cap

	12/31/02	12/31/01	Increase <Decrease>
Maryland Average Wage	$39,360	$38,255 [2]	$1,105
10 Percent of Wage	$3,936	$3,826	$110
% Increase/year (Decrease)	2.88%	5.17%	<2.29%>
Avg. Cost per Employee [3]	$3,813	$3,537	$276
% Increase/year (Decrease)	7.80%	9.03%	<1.23%>
% of Cap at 10%	96.87%	92.45%	4.42%

The CSHBP met the statutory requirement of remaining below 10 percent of Maryland's average annual wage as of the end of calendar year 2002. In 2002, the increase in the average cost of the CSHBP per employee (7.80%) exceeded the increase in the average annual wage (2.88%). This is the fifth consecutive year where the increase in the cost of the plan exceeded the wage increase.

Additional Information from the Carrier Survey:

- The number of covered lives in the small group market declined for the fourth consecutive year (down 1.69%). This decline appears to be happening nationally also, in all market sizes, mainly due to several years of double digit premium increases and increased employee cost sharing. However, overall enrollment has increased from 402,411 in 1995 to 448,080 in 2002, more than an 11-percent increase in the number of covered lives.

- The number of employers participating in the CSHBP increased slightly in 2002, by 0.79%. This trend, like the number of covered lives, seems to be consistent with what is occurring nationally. Most analysts believe that the continuous double-digit premium increases in the overall health insurance market are making group plans too expensive for employers in general and for small employers in particular. However, since 1995, the number of employer groups purchasing the CSHBP has increased 20%.

- As in prior years, staff measured the number of carriers participating in the small group market as the number of carriers by delivery system actually having covered lives, rather than the number of carriers filing rates with the MIA. The

[2] This figure is per a memo from DLLR dated May 12, 2003. Calculations in this report may differ from those reported in the June 2002 carrier survey where the average annual wage for 2001 was estimated at $38,329.

[3] The average rate of the CSHBP is established through a formula recommended by the Commission's consulting actuaries. The recommended formula calculates the "average cost per employee." The average cost per employee is the annualized result of multiplying the average premium earned per member month by the average number of covered lives per contract.

total number of participating carriers declined from 14 carriers in 2001 to 13 carriers in 2002. Twelve of these thirteen carriers offer coverage in all four geographic regions of the State.

- The dominance in coverage of the twelve prominent carriers in the small group market increased slightly in 2002, (1.81%). They now account for 93.67% of the business in the small group market.

Overall, the composite CSHBP has remained under the statutorily mandated affordability cap since 1995. In addition, the overall number of covered lives and employer groups has increased. Still, five consecutive years where premium increases have exceeded average annual wage increases in Maryland's small group market and markets in other states is cause for concern. These double-digit premium increases coupled with recent reductions in covered lives suggest additional alternatives should be explored. Much of the initial increase in covered lives and employer groups after the 1993 small group reforms was due to offering coverage to those previously excluded from coverage by mandating guaranteed issue and renewal of policies and eliminating medical underwriting. Any new reform proposals should take into consideration the optimal balance between increased choice of coverage options to enhance price competition and risk segmentation which will raise premiums for the sick who benefited from the 1993 reforms.

Health Care Costs and Their Effect on Insurance Premiums

Health insurance premiums are projected to increase at an average of about 12% per year in Maryland's small group market. This phenomenon, to one extent or another, is being experienced across all markets (large group, small group, individual) and across the nation. Premium increases, however, are merely a symptom of the underlying increase in health care costs in general. There are a number of factors that contribute to increasing health care costs. Increases in the cost of and utilization of physician services, hospital inpatient and outpatient services as well as prescription drug costs all contribute to increases in health care costs.

A key short-term cost driver is the retreat from tightly managed care that characterized the health insurance market in the 1990s. Recently there has been a decline in prior authorization requirements and an increase in easier access to specialists. Broad networks which have been demanded by consumers led to higher prices for services. With no exclusive networks, the managed care industry has seen a decrease in the need for competition thereby leading to greater consolidation within the industry. In addition, as managed care loosens its grip, there has been provider consolidation and push-back which has led to the demand for higher reimbursement from the insurance industry. Hospitals also pass along the wage increases that they have been granting to address labor shortages, especially in the area of nursing. Consumer demand has been unleashed and the cost of increased demand manifests itself in higher health care costs which then translate to increased premiums.

New technology is thought to contribute to increasing health care costs. There are new procedures, new applications of old procedures and many technological innovations that may reduce unit costs but generate increased demand and increased volume in services provided. New, more expensive, pharmaceuticals are available as well. These technological advances do not occur in a vacuum. The public expects new technologies, new procedures, new drugs, and new cures. Direct-to-consumer advertising of pharmaceuticals has enhanced this demand. Physicians and hospitals that do not offer the newest services will be avoided as patients search for advanced technologies.

In addition to underlying health care cost increases, the cyclical nature of insurance impacts premiums as well. According to a June 2003 article in *Health Affairs* that tracked health care costs:

> "Premium increases have been larger than underlying cost increases for a number of years now. This is a characteristic of the "hard" phase of the health insurance underwriting cycle, when insurers raise premiums more rapidly than underlying costs to make up for past financial losses, a practice known as "catch-up pricing." During this phase, insurers focus on restoring and solidifying profitability rather than gaining market share. Cost increases in 2000 and 2001 might have exceeded what insurers had predicted in those years, which might have delayed the planned recovery of profit margins and stretched out the current phase of the underwriting cycle. But the end of the string of successively higher cost trends in 2002 could bring the next turn in the underwriting cycle closer."[4]

Market Consolidation and Competition

Employers continue to express concern about the lack of competition in Maryland's small group market. However, a recent independent study comparing Maryland's small group market with other states did not find a significant difference in market concentration between highly regulated and loosely regulated states. Given that there is a high degree of market concentration across all states, regardless of their regulatory system, it may be that the health insurance industry itself, with its economies of scale, tends toward limited numbers of carriers.[5] There appears to be an oligopolistic tendency to the health insurance industry as the nature of insurance calls for the pooling of risk across the largest number of lives possible. A number of other factors appear to be driving consolidation among health plans[6] including:

- *Market Share*: Increasing membership is one way plans maintain profitability
- *Cost Savings*: Merged plans gain leverage in price negotiations with providers
- *Expansion*: Plans gain new markets and add new products
- *Strategic Positioning*: Plans may anticipate radical system changes (e.g., single

[4] Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Trends Stabilize But Remain High in 2002," *Health Affairs*. June 11, 2003.
[5] Elliot K. Wicks, Ph.D., "Assessment of the Performance of Small Group Market Health Insurance Reforms in Maryland." Health Management Associates, February 19, 2002.
[6] Maryland Health Care Commission, *Maryland Commercial HMOs and POS Plans: Policy Issues*, January 2004 (forthcoming).

payer) and seek ways to be a dominant player.

The implications of consolidation are varied and wide-ranging including:

- *Domino Effect*: Mergers create a wave of additional consolidation by pressuring plans to maintain market share
- *Provider Response*: Providers form alliances to protect their bargaining power
- *Choice*: Generally, employers have fewer choices; however, for employers located in multiple states, the large national plans make contracting easier. Consumers may have fewer plan choices and providers may face limited options for obtaining patients
- *Costs*: Fewer redundancies in the system may save health care payers money. However, less competition may translate into higher premiums.
- *Standardization*: Greater standardization in health care delivery structures and processes may reduce administrative burdens for physicians and promote new information systems for improved patient care.

Study of Issues Related to the Small Group Market

Under Senate Bill 477 (2003), the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration, is required to conduct an analysis of and make recommendations on the administrative cost of health plans in the small group market, including: (1) the total amount and distribution of administrative costs; (2) the strategies for lowering administrative costs; and (3) the appropriateness of the medical loss ratios specified in § 15-605(c)(1) of the Insurance Article.

In addition, Senate Bill 477 (2003) requires the Commission to prepare a report on: (1) the methodology used by the Commission in developing the Comprehensive Standard Health Benefit Plan (CSHBP) in the small group market; and (2) the feasibility of creating a Basic Plan in addition to the Standard Plan in the small group market.

Finally, the Commission wanted to explore and present information on some additional potential options to change the small group market that could only be implemented through statutory changes. Some of these are based on legislation introduced during the 2003 session but not enacted and others are based on options that have been put forth in other states, proposed at the federal level, or have been reported in academic literature. These options include: Purchasing Pools, Reinsurance, Tax Credits, and List Billing of Individual Policies.

The following report is organized under the following subsections:

I. Administrative Costs of Health Plans
II. Methodology for Developing the Comprehensive Standard Health Benefit Plan
III. Report on the Feasibility of a Basic Plan
IV. Other Potential Changes to the Small Group Market

I. Study of the Administrative Costs of Health Plans in the Small Group Market

Study of the Administrative Costs of Health Plans in the Small Group Market

Under Chapter 93 of the 2003 Laws of Maryland (SB 477), the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration, is required to conduct an analysis of and make recommendations on the administrative cost of health plans in the small group market, including: (1) the total amount and distribution of administrative costs; (2) the strategies for lowering administrative costs; and (3) the appropriateness of the medical loss ratios[1] specified in § 15-605(c)(1) of the Insurance Article.

The Commission has contracted with Mercer Human Resource Consulting (Mercer) to provide background information and analysis of this issue. The attached Mercer report explores the portion of health insurance premium that is not paid out as reimbursement to health care providers. It includes profit and risk charges, administration, marketing, and taxes.

As a percentage of total cost, these non-claim expenses are higher in the commercial market than government coverage primarily because of additional types of expenses included such as taxes and marketing and because these expenses are divided by a smaller per capita claims cost. On a cost per member basis, commercial expenses may actually be lower when excluding expenses unique to the commercial market.

The small group market in Maryland has remained above the minimum loss ratio requirement of 75%; however, the actual experience for some carriers with a small market share has occasionally fallen below the minimum.

The loss ratio requirement in Maryland is at the upper end of the range of requirements of other states but does not appear to create a burden to carriers. If the loss ratio requirement is increased, it could actually reduce availability of coverage if carriers view it as a profit reduction. It could also create an increase in the cost of coverage if claims management is reduced and this leads to a higher claims expense because of potential claims fraud and inefficient use of services.

Conclusions and Recommendations

In Maryland's small group health insurance market, approximately 15% of the premium is used to cover administration and marketing expenses. This seems reasonable when reviewing reports on other markets. Based on national data, the majority of these expenses are for account and membership administration. The next largest portion is for marketing. Next is corporate services and then medical and provider management.

[1] Medical Loss Ratio is generally defined as the portion of each premium dollar that is spent for health care claims. For example, a 75% loss ratio means that 75 cents of each premium dollar is being spent on health care claims.

Strategies for lowering administrative costs

If the minimum loss ratio requirement is increased to put pressure on reducing premiums, the market could react negatively by:

- If the only possible reduction in expenses is viewed as coming from profit and risk charges, some carriers may withdraw from the Maryland market and invest their resources in markets that provide a greater return for their investors.

- If claims administration is viewed as a possible area of cost reductions, carriers may reduce their claim fraud and claim management (including utilization management) budgets which could lead to increases in paid claims which would increase the required premium.

- If marketing is viewed as an area for cost reduction, commissions could be reduced which could reduce the number of agents interested in marketing to small groups.

On the positive side, carriers could also find ways to reduce expenses and address fraud more effectively by getting the members more involved in reducing fraud.

Although most carriers state that they are utilizing disease management programs, there appears to be a need for improvement in the care being provided to populations with certain high-risk diseases, including diabetes, cardiovascular care, and certain mental health conditions. According to the Commission's HMO Performance Report, while rates for many of the generally accepted measures of care for these diseases have been increasing, there is still room for improvement. It should be noted, however, that implementing more aggressive disease management programs could actually increase administrative costs while reducing medical costs (claims would be lower because the care is managed). In this case, the short-term shift of the portion of the premium dollar from medical to administrative would be appropriate because better quality care would be delivered. Over time, the result would be a decrease in the medical loss ratio along with a decrease in the premium rate.

Appropriateness of current statutory loss ratios

Few states have a minimum loss ratio requirement of 75% or greater. Based on a comparison to other states and taking into account the percentage of premium that is used for administrative and marketing expenses, Maryland's minimum loss ratio seems reasonable. Net income, which includes profit and risk charges, of 6% of sales (premiums) reported by Maryland carriers, is reasonable when compared to the entire life and health insurance industry net income of 7%. In addition, compared to other for-profit industries, it appears that the minimum loss ratio requirements across the country have kept the net income percentage below the net income level of most other industries while still allowing a profit.

MERCER HUMAN RESOURCE CONSULTING
ANALYSIS OF SMALL GROUP MARKET
ADMINISTRATIVE EXPENSES

Introduction

The purpose of this report is to understand the expenses under an insured group health plan other than health care service expenses. The report will address the sources of these expenses, compare the expenses to Maryland's minimum loss ratio requirement, compare Maryland's minimum loss ratio requirement to the minimum loss ratio legislated in other states, and compare the net income of the life and health insurance industry to other industries.

Sources of Non-Claims Expenses

In this section we summarize our research on the sources of non-claims expenses.

Non-claims expenses include several types of expenses incurred by carriers to provide health coverage. Some expenses are required just to maintain business, such as claims administration, billing, provider relations, general administration, and taxes. Some expenses are incurred in order to promote business, such as product management, marketing, research, and development. Other expenses are incurred to reduce claims expenses, such as provider contracting, underwriting, utilization management, fraud prevention, and wellness and health education. If expenses incurred for activities to reduce claims expenses are successful (e.g., disease management programs), the result will actually be a decrease in the loss ratio along with a decrease in the premium rate.

In the Commonwealth Fund, June 11, 2003 report, *American Health Care: Why So Costly?*, they present that the fragmentation of the coverage system is part of the reason for the high cost of insurance.

> The fragmentation of the U.S. health insurance system-with people moving in and out of coverage and in and out of plans, and changing their usual source of care frequently-all contribute to high administrative costs for insurers and health care providers. In 2002, the U.S. health system spent $112 billion on administrative expenses, and expenses are expected to hit $223 billion in 2012.
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> Administrative costs for private insurance include marketing, sales and commissions, profits and reserves, as well as the cost of enrolling individuals and paying claims. Government programs, by contrast, do not incur marketing and sales expenses and do not require premiums high enough to generate profits and reserves. On average, administrative expenses for private insurers are 11.9 percent of their health care expenditures. The costs of administering government programs (including not only Medicare and Medicaid but Veterans Administration, Department of Defense, Indian Health Service, and other direct health services delivery programs) average 4.6 percent of health expenditures-less than half of private insurance.

In another report by the Commonwealth Fund, *Time For Change:The Hidden Cost of a Fragmented Health Insurance System*, March 10, 2003, there is additional information on the cost of fragmentation.

> This churning in health insurance coverage also imposes a hidden cost on the U.S. health system. Every time an individual or family signs up for insurance coverage, whether public or private, there is a cost of enrollment. There are other costs when disenrollment or reenrollment occurs.
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> Consolidation in the managed care industry, with mergers and conversions, added to this instability. Plan withdrawals from selected geographic areas also required many Medicare, Medicaid, federal employees and privately insured individuals to change coverage.
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> Not surprisingly, both the U.S. spending on health insurance program administration and the net cost of private health insurance have soared over the last three decades. In 1970, the U.S. spent $2.8 billion on administrative costs. In 1980, it was $12.1 billion. By 1990 it was $40 billion. In 2002 it was $110.9 billion. By 2012 it is expected to reach a staggering $222.6 billion or 8 percent of all personal health care expenditures.

In a September 2002 report by the Health Insurance Association of America (HIAA), *Issue Brief: Why Do Health Insurance Premiums Rise?*, they explore non-claims expenses by type of contract.

> The primary components include claims administration, general program administration (for example, enrollment, billing, legal, actuarial, and other management expenses), marketing expenses, state taxes (premium taxes, licenses, and fees), federal income taxes, and profit. Due to economies of scale and the fixed nature of certain costs, the percentage of health insurance premiums represented by these expenses is generally lower for employer-sponsored group health plans than for individually purchased health insurance. For group plans, expenses tend to decrease as the size of the group increases. Administrative costs also vary by health delivery system.
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> Survey data collected in 1991 by HIAA indicate that for mid-size employer groups (100 to 499 employees), claims administration expenses represented 3 percent of premiums. General program administration was 5 percent of premiums, marketing and distribution expenses were 2 percent, and state taxes another 2 percent. Federal taxes represented 1 percent of premiums and profit an additional 1 percent. Overall, administrative and other expenses accounted for 14 percent of premiums for these employers.
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> For small groups (fewer than 25 employees), expenses represented a somewhat higher percentage of premiums. Claims administration was 4 percent, program administration 6 percent, and marketing and distribution were 6 percent of premiums. State taxes were 3 percent, federal taxes 2 percent, and profit was 4 percent of premiums. On a national basis, the administrative costs incurred by insurers represent

approximately 6 percent of total personal health expenditures. These costs are, in aggregate, lower than administrative costs incurred by hospitals or by physicians.

The profit margins of commercial health insurers have historically represented a small percent of overall premiums. For the period between 1976 through 1995, claims and administrative expenses for the top 20 commercial group insurers exceeded premiums, producing an average underwriting loss of 1.7 percent of premiums. Net operating earnings, which primarily reflect the addition of investment earnings and federal income taxes, showed an average gain equal to 1.87 percent of premiums. Results were similar for the individual health insurance policies issued by those same companies. Claims and administrative expenses exceeded premiums by 4.7 percent. Net operating gain for the period averaged 3.8 percent of premiums. The net after tax profit for commercial insurers was 0.4 percent in 1998. Average profit margins for health maintenance organizations (HMOs) have declined from 8 percent in 1994 to less than 1 percent in 1997. About 56 percent of HMOs lost money in 1998 and profits continued to fall in 1999.

The picture is no different when publicly traded insurers are viewed as an investment of capital. The average return on equity for insurers is significantly below that of the S&P 500. By comparison, hospital profit margins are more than twice that of insurers, medical product and supply companies more than triple, and at more than 16 percent, profit margins for biotechnology and pharmaceutical companies have even more significantly exceeded those of health insurers.

Low margins for commercial health insurers mean that increases in the underlying benefit costs have a direct and significant impact on premiums paid by employers and individual consumers.

Despite evidence to the contrary, public opinion surveys show that Americans believe the health insurance industry in general, and in particular those insurers using managed care, are highly profitable. One recent survey found that 95 percent of Americans believe that insurance industry profit margins exceed 10 percent and over 40 percent believed profits exceeded 25 percent.

Managed care techniques complicate the analysis of administrative costs. In general, utilization review, anti-fraud activities, and other cost management programs represent new administrative expenses that reduce overall spending. For instance, HIAA data show that health insurers' anti-fraud activities in 1998 saved more than $11 for every dollar spent. As a result of these important and cost-effective activities, the percent of premiums attributed to administrative expenses tends to rise.

In addition, the way a network-based health plan contracts with providers may affect the accounting for administrative expenses. Amounts paid to providers or provider groups, in general, are treated as benefit costs. In a managed care environment, provider groups may be responsible for administrative functions that would otherwise be performed by the health plan administrator. If the reimbursement for those services is included in the overall capitation, then it will be treated on the insurer's books as a benefit cost rather than an administrative cost. This makes comparisons of administrative cost levels between different types of health benefit programs very difficult.

> It is particularly difficult to compare voluntary private programs and mandatory social insurance programs. Private programs have many types of expenses, for instance, marketing and taxes, which have no direct parallel in a social insurance program. Billing, product development, and regulatory compliance also are typically much more significant in a private insurance program. In addition, it may be difficult to fully capture all of the expenses associated with a social insurance program. Billing may be replaced by tax collection, as in the Medicaid program, or may be integrated into another social insurance program, as with Medicare. In either case, revenue collection is not directly associated with the health insurance program itself. Certain legal and audit services may be provided by other government entities. Much of the cost of product development becomes part of the political process rather than an administrative function of the insurance program.
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> In the Medicare program, administrative expenses are partially placed on the private entities that assist in program administration. These entities must perform all the required program administration, including eligibility verifications, coverage determinations, coordination of benefits between sources of coverage, and benefit payments. In addition, they must conduct other services such as fraud detection.
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> In addition, while the dollars spent per claim for program administration may be relatively equal between Medicare and private programs, the average claim amount may be significantly higher for Medicare than for private programs. This causes the percentage spent on administration to be much smaller. Private programs cover frequently used services such as prescription drugs, which have relatively lower average claim costs, compared to hospital services with higher average costs.
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> Overall, mandatory social insurance programs appear to have somewhat lower administrative expenses than private insurance programs. However, economic theory suggests that private markets are superior to centrally planned systems in allocating resources efficiently. Further, government-run health care systems have not been without their own problems. Private health insurance systems can provide an array of coverage options to consumers. Without the discipline of market competition, social insurance systems can become unresponsive. In addition, these programs may not allocate sufficient resources to effectively combat fraud and abuse.

In October 2001, the Government Accounting Office (GAO) published the report, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage*. In this report, the GAO explores the non-claims expenses for small groups and how they compare to large groups.

> Insurers' administrative costs and expenses (other than benefits) are higher for small employers than for large employers. As a result, insurers spend a smaller share of small employers' premium dollars on benefits and more on administrative and other expenses than they do for large employers'. For smaller employers, administrative costs such as marketing and billing are spread over fewer people. Furthermore, because large employers typically assume the risk for their employee health benefits by self- funding rather than purchasing insurance, other expenses, such as premium taxes, can be avoided. Insurers also report the potential for adverse risk selection- or

purchasing of insurance by those with relatively high health care needs- is greater with the smallest groups, and to remain financially viable, insurers generally take steps to avoid covering a disproportionate share of these costly groups. Therefore, insurers may attempt to mitigate the difficulty of predicting the risk of a small group compared to a large group by reviewing the medical history of individuals in the group- called medical underwriting- or adding a premium surcharge to better ensure that they can cover costs resulting from unexpectedly large health care costs.

Our analysis of existing data indicates that, overall, insurers' administration costs and expenses, other than benefits, typically account for about 20 percent to 25 percent of small employers' premiums compared to about 10 percent of large employers' premiums. These expenses can range from around 5 percent to 30 percent of the premium dollar, depending on the size of the employer, type of plan, and insurer. The smaller the size of the group the larger the share of the premium that goes towards paying for expenses other than benefits. This is due in part to the fact that small employers have fewer individuals over which to spread expenses and certain costs are lower or can be avoided by large employers. Insurers' administrative activities, such as marketing and billing, increase small employers' premiums more because, with fewer people to share the costs, they cannot obtain the financial savings afforded to larger groups. For example, if it costs an insurer $5 a month to generate a bill for each employer, this cost spread over a group of five people would increase each person's monthly premium by $1. In contrast, for a group with 100 people this same activity would increase the monthly premium for each person by only 5 cents.

In addition, some expenses associated with insurance for most small employers may be avoided or reduced for large employers who assume the financial risk for their employees' health coverage or perform some administrative functions internally. By self- funding, large employers avoid expenses such as state premium taxes assessed on insurance sold in the state that typically represent about 1 percent to 3 percent of health insurance premiums. In addition, large employers may perform some administrative activities, such as employee enrollment and education, which insurers or agents perform for, and therefore charge, small employers. Large employers typically purchase insurance with the assistance of benefits consultants, whom they pay a fixed hourly or lump sum fee. A recent survey by Kaiser/ HRET estimated that the average administrative cost borne internally by large employers- those with 200 or more employees- for providing health benefits is approximately $250 per covered worker. This would increase the cost per covered employee by approximately 6 percent. Small employers, on the other hand, typically purchase insurance through agents whose fees can account for as much as 8 percent to 10 percent of the insurance premium (See Note below[2] for Maryland information).

Furthermore, some insurers may add a surcharge of 1 percent to 5 percent of small employers' premiums to increase their financial reserves- a pool of money they invest to help ensure that there will be sufficient funds should an unanticipated large expense occur. This surcharge tends to be higher when the insurer is less certain of the risk of

[2] According to the Maryland Association of Health Underwriters, the National Association of Insurance and Financial Advisors of Maryland, and several brokers contacted by the Commission, as well as analysis of plan data provided by the Maryland Insurance Administration to Commission staff, broker commissions for the small group market business in Maryland are generally in the range of 3% to 6% of premium.

the group and may be imposed in lieu of or in addition to medical underwriting. However, not all states permit these activities and not all insurers underwrite small groups or add a risk surcharge.[3]

The following information is from the Sherlock Company which publishes monthly reports with national analytics for health plan administration.

- Their report for August 2003 shows that for publicly traded health insurers:
  - Expenses as a percentage of revenue is 12% for insured HMO, POS and PPO contracts, 7% for Medicare Plus Choice, 8% for Medicaid HMO, and 12% for Medicare Supplement.
  - On a per member per month basis, the average administrative expenses are $22 for insured HMO, $25 for insured POS, $23 for insured PPO, $45 for Medicare Plus Choice, $11 for Medicaid HMO, and $20 for Medicare Supplement.
  - The average allocation of expenses[4] are:
    - 26% for marketing
    - 12% for medical and provider management
    - 35% for account and membership administration
    - 24% for corporate services
    - 3% for other.
- Their report for July 2003 shows that for Blue Cross and Blue Shield Plans:
  - Expenses as a percentage of revenue is 13% for insured HMO, 15% for insured POS, 12% for insured PPO contracts, 8% for Medicare Plus Choice, 14% for Medicaid HMO, and 13% for Medicare Supplement.
  - On a per member per month basis, the average administrative expenses are $23 for insured HMO, $26 for insured POS, $25 for insured PPO, $49 for Medicare Plus Choice, $21 for Medicaid HMO, and $19 for Medicare Supplement.

[3] Note: Maryland law is silent on the issue of "surcharges" (more commonly referred to as "risk charges"); they are not explicitly allowed nor are they explicitly prohibited. A risk charge is an amount added to premium to provide a financial cushion to guard against unexpectedly high claims. Insurance companies generally increase their risk charge as the probability for fluctuations in claims increases.

[4] **Marketing** expenses included Rating and Underwriting, Product Development / Market Research, Sales and Marketing, Commissions and Advertising and Promotion. **Medical & Provider Management** was composed of Provider Network Management and Services and Medical Management (including Quality Assurance), Wellness Programs and Grievance/Appeals. **Account & Membership Administration** includes many of the core functions such as Enrollment (including Membership and Billing), Customer Services, Information Systems and Claims (including Encounter Capture and Adjudication). **Corporate Services** represented the final category. It included investments in HIPAA compliance as well as Finance and Accounting, Actuarial, Corporate Services (including Human Resources, Facilities, Legal and Regulatory, Corporate / Executive and Association Dues and Miscellaneous Business Taxes.

- The average allocation of expenses are:
  - 23% for marketing
  - 10% for medical and provider management
  - 38% for account and membership administration
  - 22% for corporate services
  - 6% for other.

In a February 20, 2003 Milliman USA report, Blue Cross Blue Shield Association – Health Plan Administrative Cost Trends, they analyze plan administrative cost trends on insured business for 1998 through 2002. They found that while premiums increased at an annual rate of 7.4%, administrative expenses increased at a lower rate of 4.6%. Because of this difference, administrative expenses as a percentage of premium fell from 12.9% to 11.6%. Also, they estimate that 60% of the increase in administrative expenses was related to increases in staffing costs. Most of the increase in staffing costs was related to customer service and technology staffing.

The Minnesota Department of Health (MDH) collects information from carriers in the Minnesota market on indirect administration expenses. Indirect expenses exclude taxes. The information is a combination of individual, insured group, self-funded group, Medicare, Medicaid, and other health plans; therefore, it is difficult to compare the Minnesota data to information about only the small group market in Maryland. MDH asks carriers to report their administration expenses segregated into the following 14 categories:

- Billing and enrollment
- Claim processing
- Detection and prevention of fraud
- Customer services
- Product management and marketing
- Underwriting
- Regulatory compliance and government relations
- Lobbying
- Provider relations and contracting
- Quality assurance and utilization management
- Wellness and health education
- Research and product development
- Charitable contributions
- General administration.

The accuracy of the administration expense allocation depends on the carriers' ability to segregate expenses into these categories. A couple of the smaller carriers reported all their administration expenses under "General Administration". Of the 46 carriers reporting their administration expenses in 2001, not a single carrier provided a non-zero value for each of the 14 expense categories. For example, only 27 carriers reported expenditures for detection and prevention of fraud and only 30 reported expenditures under quality assurance and utilization

management. These expenses may be included under another category such as claim processing or general administration.

In 2001, administration expenses for these 46 Minnesota carriers was reported to represent 9.4% of total health plan spending; however, this ranged by carrier from a low of 5.1% to a high of 38.2%, likely depending on the mix of business between individual, insured group, self-funded group, Medicare, Medicaid, and other health plans. The following table summarizes the average health care expenses, as a percentage of total spending, by expense category, using the reported expenses.

Table 1: Minnesota Indirect Health Plan Expenses in 2001

Indirect Expense Category	Cost as a Percentage of Total Spending	Cost as a Percentage of Total Indirect Expenses
Billing & Enrollment	0.6%	6.7%
Claim Processing	1.8%	19.3%
Detection & Prevention of Fraud	0.0%	0.3%
Customer Service	0.7%	7.7%
Product Management & Marketing	1.8%	19.7%
Underwriting	0.2%	2.0%
Regulatory Compliance & Government Regualtions	0.1%	1.5%
Lobbying	0.0%	0.2%
Provider Relations & Contracting	0.4%	4.3%
QA & Utilization Mangement	0.7%	6.9%
Wellness & Health Eduction	0.1%	1.1%
Research & Product Development	0.2%	2.2%
Charitable Contributions	0.0%	0.3%
General Administration	2.6%	27.8%
Total Indirect Health Care Expenses	9.4%	100.0%

The majority of indirect expenses are classified as general administration. For the expenses that carriers could segregate, the largest portion falls under product management and marketing. The next largest portion falls under claims processing. Combined, these three categories make up over two-thirds of the indirect expenses.

Some expenses can vary significantly from year to year. For example, regulatory compliance can vary based on new regulations that are passed in a given year. Recent HIPAA regulations required carriers to make system changes to protect members' privacy. Depending on how these expenses are reported, it could skew the expenses in a given year.

Comparison of Small Group Expenses and Risk Charge to Maryland's Minimum Loss Ratio

In Maryland, insured health products are subject to a minimum loss ratio requirement of 75%. Annually, the carriers in the small group market report their financial experience to the MHCC. The following is a summary of the portion of premium not used for claims for 2000 through 2002.

Table 2: Maryland Small Group Non-Claim Allocation as a Percentage of Premium

Category	2000	2001	2002
Administrative Expenses[5]			
PPO	15%	13%	13%
POS	21%	20%	16%
HMO	16%	15%	15%
All Plans	17%	15%	14%
Profit & Risk			
PPO	6%	8%	8%
POS	4%	4%	4%
HMO	-1%	5%	5%
All Plans	1%	6%	6%
Total Other than Claims			
PPO	21%	21%	21%
POS	25%	24%	20%
HMO	15%	20%	20%
All Plans	18%	21%	20%

This shows that for the past three years, because claims represent at least 75% of premium, the market has remained above the minimum loss ratio. Because of unexpected fluctuations in claims experience, the experience for some carriers with a small market share has fallen below the minimum. We assume that the rates filed with the MIA targeted a loss ratio above 75%. The expenses allocated to the small group plans has decreased as a percentage of premium, while profit and risk charges[6] have increased.

[5] Administrative expenses would include account and membership administration, marketing, corporate services, and medical and provider management.

[6] A risk charge is an amount added to premium to provide a financial cushion to guard against unexpectedly high claims. Insurance companies generally increase their risk charge as the probability for fluctuations in claims increases.

Comparison of Maryland's Minimum Loss Ratio to Requirements in Other States

According to the Maryland Insurance Administration, "All small group carriers file at least 75% loss ratio targets in their filings for Maryland... nothing less than that 75% is permitted. The only real credible instance of a carrier actually falling below the 75% benchmark in Maryland (as claim experience developed) involved BlueChoice, a situation which the MIA has strongly addressed since mid-2002 via significant rate rulings which have brought BlueChoice above the 75% benchmark."

Few states have a minimum loss ratio requirement of 75% or greater. The majority of states are either less restrictive or silent on a minimum loss ratio requirement.

The state of Washington has a minimum loss ratio of 80% for insured groups with 100 or more employees, but it reduces down to 75% for 50 to 99 employees, 70% for 25 to 49 employees, 65% for 10 to 24 employees, and 60% for 2 to 9 employees.

North Carolina has a 75% minimum loss ratio requirement; however, it applies only to full service HMOs.

North Dakota has a 75% minimum loss ratio requirement for all group coverage.

Kentucky has a 75% minimum loss ratio requirement for groups with 11 to 50 employees, but it is lowered to 70% for groups with 2 to 10 employees. No requirement applies to groups with over 50 employees.

Maine is adopting a minimum loss ratio requirement of 75% for filed rates on groups of 1 to 50 employees. A carrier can opt not to file rates if they guarantee a minimum loss ratio of 78%. These requirements are effective July 1, 2004.

New Jersey has a minimum loss ratio requirement of 75% for groups with 2 to 50 employees. In addition, the New Jersey Department of Insurance does a retrospective review, and if a carrier does not achieve a 75% loss ratio, the carrier must issue refunds to make up the difference.

Based on this comparison, Maryland's minimum loss ratio seems reasonable. Maryland may want to consider adopting a retrospective review feature like the one in New Jersey; however, this may lead to carriers adding a risk charge to cover a potential refund. Also, the refund may be a considerable portion of premium for carriers with a small market share and a high variance in claims experience. In addition, refunds for small group are potentially expensive to administer and could actually add to costs.

Comparison of Net Income by Industry

Most health carriers are for-profit insurance companies or HMOs. In establishing a minimum loss ratio, legislators want to permit a reasonable profit while preventing insurance companies from generating an excessive profit. The following table summarizes reported net income as a percentage of sales by industry. The table is based on net income and sales information from Bizstats (www.Bizstats.com) for 2001 and 2002. The life and health insurance industry has an average net income equal to 7.0% of sales.

Table 3: Net Profit as a Percentage of Sales by Industry

Construction	Net Income as % of Sales
General building contractors	1.9%
Operative builders	4.0%
Heavy construction contractors	3.2%
Plumbing, heating, and air conditioning	2.6%
Electrical contractors	3.6%
Other special trade contractors	3.3%
Retail trade	**Net Income as % of Sales**
Building material dealers	3.4%
Hardware stores	0.6%
Garden supplies	2.1%
General merchandise stores	2.8%
Grocery stores	1.4%
Other food stores	2.1%
Motor vehicle dealers	0.8%
Gasoline service stations	0.7%
Other automotive dealers	2.0%
Apparel and accessory stores	3.5%
Furniture and home furnishings stores	1.6%
Eating and drinking places	2.5%
Drug stores and proprietary stores	2.3%
Liquor stores	1.0%
Other retail stores	2.1%
Wholesale trade	**Net Income as % of Sales**
Groceries and related products	1.0%
Machinery, equipment & supplies	3.4%
Motor vehicles & automotive equipment	1.3%
Furniture and home furnishings	3.3%
Lumber and construction materials	1.8%
Toys, sporting & photographic goods	2.6%
Metals and minerals	1.6%
Electrical goods	1.0%
Hardware, plumbing & heating equipment	2.7%
Other durable goods	1.7%
Paper and paper products	1.4%
Drugs, & drugstore sundries	0.8%
Apparel, piece goods, and notions	3.2%
Farm-product raw materials	0.6%
Chemicals and allied products	1.9%
Petroleum and petroleum products	1.1%
Alcoholic beverages	3.1%
Other non-durable goods	2.1%

Table 3: Net Profit as a Percentage of Sales by Industry (cont.)

Services	Net Income as % of Sales
Hotels and other lodging places	**4.4%**
Personal services	**5.4%**
Advertising	**2.7%**
Miscellaneous Business services	**4.8%**
Auto repair and services	**1.3%**
Miscellaneous repair services	**3.3%**
Motion picture production & distribution	**2.7%**
Motion picture theaters	**2.5%**
Other Amusement & recreation services	**4.7%**
Offices of physicians	**1.2%**
Offices of dentists	**3.6%**
Offices of other health practitioners	**5.2%**
Nursing and personal care facilities	**1.1%**
Hospitals	**1.5%**
Medical laboratories	**-5.6%**
Other medical services	**0.5%**
Legal services	**4.8%**
Educational services	**1.7%**
Social services	**1.9%**
Membership organizations	**3.1%**
Accounting & auditing services	**5.4%**
Miscellaneous services	**2.1%**
Manufacturing	**Net Income as % of Sales**
Meat products	**1.7%**
Dairy products	**2.3%**
Preserved fruits and vegetables	**5.9%**
Grain mill products	**6.1%**
Bakery products	**3.8%**
Sugar and confectionery products	**6.3%**
Malt liquors and malt	**10.1%**
Alcoholic beverages, except malt liquors	**14.6%**
Bottled soft drinks and flavorings	**9.8%**
Other food and kindred products	**3.2%**
Tobacco manufactures	**0.0%**
Weaving mills and textile finishings	**2.8%**
Knitting mills	**3.0%**
Other textile mill products	**3.6%**
Men's and boys' clothing	**7.0%**
Women's and children's clothing	**2.6%**
Other apparel and accessories	**1.3%**
Miscellaneous fabricated textile products	**2.3%**
Logging, sawmills, and planing mills	**1.1%**
Millwork, plywood, and related products	**2.2%**
Other wood products	**5.1%**
Furniture and fixtures	**0.0%**
Pulp, paper, and board mills	**1.9%**
Other paper products	**5.9%**
Newspapers	**14.9%**
Periodicals	**1.9%**
Books, greeting cards, and other publishing	**5.9%**
Commercial and other printing services	**3.9%**
Industrial chemicals, plastics & synthetics	**7.4%**
Drugs	**15.4%**
Soaps, cleaners, and toilet goods	**11.5%**
Paints and allied products	**7.0%**

Table 3: Net Profit as a Percentage of Sales by Industry (cont.)

Manufacturing (Cont.)	Net Income as % of Sales
Agriculture and other chemical products	**5.0%**
Petroleum refining	**6.6%**
Petroleum and coal products	**-1.8%**
Rubber products, hose & belting	**5.7%**
Miscellaneous plastics products	**4.8%**
Footwear, except rubber	**4.0%**
Leather and leather products	**1.6%**
Glass products	**5.8%**
Cement, hydraulic	**14.3%**
Concrete, gypsum, and plaster products	**8.2%**
Other nonmetallic mineral products	**4.0%**
Ferrous & primary metal products	**2.5%**
Nonferrous metal industries	**4.4%**
Metal cans and shipping containers	**1.8%**
Cutlery, hand tools, and hardware	**13.4%**
Plumbing and heating, except electric	**7.5%**
Fabricated structural metal products	**5.8%**
Metal forgings and stampings	**5.1%**
Coating, engraving, and allied services	**6.4%**
Ordnance and accessories	**6.4%**
Miscellaneous fabricated metal products	**6.4%**
Farm machinery	**8.8%**
Construction and related machinery	**7.9%**
Metalworking machinery	**6.1%**
Special industry machinery	**4.5%**
General industrial machinery	**8.1%**
Computers & office machines	**8.2%**
Other machinery, except electrical	**4.7%**
Household appliances	**3.2%**
Radio, TV and communication equipment	**4.6%**
Electronic components and accessories	**8.1%**
Other electrical equipment	**8.2%**
Motor vehicles and equipment	**3.6%**
Aircraft, guided missiles and parts	**5.2%**
Ship and boat building and repairing	**3.8%**
Other transportation equipment	**5.5%**
Scientific instruments, watches & clocks	**6.7%**
Optical, medical, and ophthalmic goods	**6.3%**
Photographic equipment and supplies	**9.2%**
Miscellaneous manufacturing	**4.8%**
Transportation and public utilities	**Net Income as % of Sales**
Railroad transportation	**3.1%**
Local and interurban passenger transit	**2.0%**
Trucking and warehousing	**2.6%**
Water transportation	**4.5%**
Air Transportation	**5.4%**
Pipe lines, except natural gas	**32.8%**
Other Transportation services	**1.6%**
Telephone & other communication services	**7.3%**
Radio and television broadcasting	**2.6%**
Electric services	**11.7%**
Gas production and distribution	**0.3%**
Combination utility services	**10.5%**
Water supply and other sanitary services	**5.6%**

Table 3: Net Profit as a Percentage of Sales by Industry (cont.)

Finance, insurance & real estate	Net Income as % of Sales
Mutual savings banks	222.7%
Bank holding companies	78.4%
Banks	21.9%
Savings and loan associations	59.3%
Personal credit institutions	13.7%
Business credit institutions	18.3%
Other credit agencies	26.2%
Security brokers & services	21.8%
Commodity brokers & dealers	12.4%
Life insurance companies	**7.0%**
Mutual property & casualty insurance companies	7.6%
Stock property & casualty insurance companies	6.2%
Insurance agents, brokers & services	8.6%
Real estate operators & building lessors	10.4%
Lessors of mining, oil & similar property	121.9%
Lessors of railroad & other real property	34.1%
Condominium management & housing associations	-3.2%
Sub-dividers & developers	3.1%
Other real estate services	4.4%
Small business investment companies	7.6%
Other holding and investment companies	68.7%
Agriculture, forestry, and fishing	**Net Income as % of Sales**
Agricultural production	2.5%
Agricultural services, forestry & fishing	2.4%
Mining	**Net Income as % of Sales**
Copper, lead and zinc, gold and silver ores	-0.6%
Other metal mining	5.1%
Coal mining	3.9%
Crude petroleum & natural gas	6.3%
Oil and gas field services	13.5%
Crushed stone, sand & gravel	7.0%
Other nonmetallic minerals	2.6%

The 6% net income reported by Maryland carriers in Table 2 for 2001 and 2002 is reasonable when compared to the life and health insurance industry net income of 7% shown above. Compared to other for-profit industries, it appears that the minimum loss ratio requirements across the country have kept the net income percentage below the net income level of most other industries while still allowing a profit.

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II. The Methodology for Developing the Comprehensive Standard Health Benefit Plan

The Methodology for Developing the Comprehensive Standard Health Benefit Plan

Overview

In 1993, the Maryland General Assembly passed House Bill 1359, "Health Insurance Reform Act of 1993" (Chapter 9 of the Acts of Maryland of 1993), which established the Health Care Access and Cost Commission ("HCACC"), one of the predecessor commissions to the Maryland Health Care Commission ("MHCC"). One of the charges of the Commission was to develop a comprehensive, affordable, and accessible package of health care benefits for Maryland's small business community.

This benefit plan was the only product that insurance carriers could sell to small employers in Maryland. The original legislation defined "small employer" as an employer with at least two but no more than fifty eligible employees[1]. Insurance carriers that chose to participate in this market were mandated to offer this benefit plan on a guaranteed issue/guaranteed renewal basis, without pre-existing condition limitations, and with rates based on adjusted community rating. Additionally, carriers were required to price this product separately from the cost of any riders or enhancements that were offered to small employers in conjunction with the standard plan. Moreover, carriers could only offer riders that enhance the benefits package, not diminish the services offered in the standard plan. Carriers began selling this benefit plan, known as the Comprehensive Standard Health Benefit Plan ("CSHBP") beginning July 1, 1994. The CSHBP is open to small employers throughout the year, and to groups of one, including bona fide self-employed individuals, during a defined open enrollment period, currently designated as the month of December.

History of the Development of the CSHBP

On July 21, 1993, then Governor William Donald Schaefer appointed a thirteen-member Standard Benefit Plan Task Force ("Task Force"), co-chaired by Thomas P. Barbera of Mid-Atlantic Medical Services, Inc. (MAMSI) and Don S. Hillier of MNC Financial. Under the law, the Task Force was required to submit its recommendations to the Commission by December 1, 1993. Governor Schaefer, recognizing the time line needed to implement the evolving regulations, reverted the due date from the legislatively established December 1, 1993 back to November 1, 1993. From the date the law was enacted through October 30, 1993, the Task Force held twelve public meetings throughout the state and received public testimony at seven of these twelve meetings. The co-chairmen submitted the Report of the Standard Benefit Plan Task Force to the HCACC chairman, William C. Richardson, Ph.D., on November 4, 1993.

[1] Subsequently, the General Assembly expanded the definition of small employer to include certain "groups of one" (including the self-employed), effective July 1, 1996.

In developing this report, relevant charges to the Task Force required that it consider the following:

1. The health benefit plans typically provided by Maryland employers to their employees, including the difference, if any, between the benefits offered under insured and self-funded benefit plans;

2. The health benefits required to be covered under federal law for federally qualified health maintenance organizations (HMOs) and under standard health benefit plans adopted by other states; and

3. The impact of the proposed Comprehensive Standard Health Benefit Plan (CSHBP) on:

    a. The ability of employers to offer or continue to offer employment-based health insurance coverage;

    b. Reducing uncompensated care borne by practitioners and hospitals; and

    c. Encouraging self-insured employers to voluntarily participate in the community rated health insurance pool.

In addition to the charges established by the Governor, the Task Force had to consider the pertinent legislative requirements that the plan not fall below the "floor" or minimum level of benefits, established by law as the actuarial equivalent of the benefits required to be offered by a federally qualified HMO and not exceed a "ceiling" or maximum cost of the CSHBP, originally established at 12 percent of Maryland's average annual wage[2]. The Task Force also was required to consider appropriate cost sharing arrangements within the CSHBP and other incentives to help control utilization of unnecessary health care services.

The Task Force report included the basic regulations, which include detailed definitions, coverages, cost sharing arrangements, and exclusions. The report also noted the following observation regarding the legislatively set "floor" or the actuarial value of the mandatory benefits for federally qualified HMOs:

> *"...While the legislation permits the standard benefit plan to exclude services required to be offered by federally qualified HMOs, practically speaking it was necessary to use not just the actuarial equivalent of the HMO benefits but the benefits themselves as a minimum. To do otherwise would mean that federally qualified HMOs could not offer benefits to Maryland's small employers..."*

[2] The 2003 General Assembly enacted SB 477, "*Small Business Health Insurance Affordability Act,"* which lowered the affordability cap from 12 percent to 10 percent.

After receiving the Task Force report, the Commission held an eleven-hour public hearing. More than 65 people testified on various aspects of the report, from reaction to the overall strategy used in developing the CSHBP to specific health care benefits recommended in the plan, such as inpatient hospital stay, mental health and substance abuse, as well as out-of-pocket costs.

Based on the comments heard at the hearing, the Commission and the Maryland Insurance Administration (MIA) jointly approved regulations to establish the Comprehensive Standard Health Benefit Plan (CSHBP). The regulations were finalized through the regulatory process and implemented by the MIA and carriers as of July 1, 1994.

Current Process for Reviewing and Modifying the CSHBP

The original law also established certain monitoring obligations of the Commission. Specifically, the Commission was required to conduct an annual review of the CSHBP to determine that the benefits included in the plan are meeting the needs of Maryland's small employers and to ensure that the overall cost of the standard plan does not exceed the statutorily-set affordability cap. Therefore, Commission staff implements the following procedure in its annual review of the CSHBP:

- By January 31st, Commission staff mails financial survey packets to all carriers participating in the small group health insurance market, requesting a filing deadline by the first week of April.

- During April and May, staff reviews and coordinates the reported data with the MIA. The two agencies ensure that discrepancies in the reports are reconciled. MHCC staff consolidates and analyzes the data and presents the *"Summary of Carrier Experience"* to the Commission at its public meeting in May or June.

- Using the staff summary as a basis, the Commission's consulting actuary analyzes the cost of the CSHBP across all six delivery systems and projects these costs for two years.

- The consulting actuary also evaluates any mandated health insurance services that were considered by the current year's General Assembly (both passed and failed) and any stakeholder issues as to their potential impact on the overall cost of the CSHBP, if the Commission elects to include them in the plan.

- The consulting actuary presents the results of its analysis at the Commission's September public meeting.

- At the same time, staff analyzes any proposed benefit changes to the CSHBP based on its summary report, passed and failed mandated benefits, any stakeholder issues that have been raised, and the results of the actuarial study. In concert with the consulting actuary, staff presents its report and recommended

changes to the CSHBP at the Commission's September public meeting. Shortly after the Commission meeting, at least one public hearing is held.

- At the October public meeting, the Commission votes on each issue. Staff then initiates the regulatory process to implement any proposed changes to the CSHBP.

- Upon approval, regulations are ready for final adoption in January or February.

- The MIA and the participating carriers implement all changes to the CSHBP on July 1st.

Over the past nine years, the Commission has modified the CSHBP regulations but they remain substantially the same as originally adopted. A list of modifications made to the plan since its inception, including the financial impact of each specific change on the overall cost of the CSHBP, is included in Appendix A. This chart does not include proposed modifications to the CSHBP adopted at the October 2003 Commission meeting that are effective July 2004.

Process for Modifying the CSHBP to Comply with the 10-Percent Affordability Cap

Statement of the Problem: As previously noted in this report, the Commission is required by law to maintain the average cost of the CSHBP at 10 percent of Maryland's average annual wage. The 2002 financial evaluation of small group market carriers determined that the "cap" was $3,936 and the average cost of the plan was $3,813, or 96.87% of the cap. Mercer, our consulting actuary, uses a slightly different methodology to annualize the average premium and estimates the average cost of the plan at $3,823, or 97.1% of the cap.

Projecting salary increases at 3 percent annually for 2003 and 2004, the cap is projected to be $4,176 in 2004. Premiums are projected to increase at 12 percent annually for 2003 and 2004 to reach $4,783 in 2004. Mercer's refined figures project premiums to increase somewhat higher, to $4,302 in 2003 and $4,794 in 2004.

Using the refined Mercer estimates, in order for the plan not to exceed 100 percent of the projected cap, the plan would need to be reduced by approximately $618 (or 12.9%). Staff initially established an objective to reduce the plan to 90 percent of the cap. To reach that level, the plan's projected premium would need to be reduced by approximately $1,036 (or 21.6%). Reducing the plan to 90 percent of the affordability cap during this evaluation period could eliminate the need for a comprehensive review of benefits and cost-sharing arrangements for a few years and provide some stability in benefit structure.

Process: On June 17th and August 21st, Commission staff conducted meetings of various interested parties/stakeholders, including insurance carriers, employers, brokers, agents, and legislators to seek input on methods for reducing the overall cost of the CSHBP.

Following the June 17th meeting, several interested parties submitted suggested changes to the plan. Based on those recommendations, Commission staff submitted a document to Mercer entitled, *"Potential Changes to the Comprehensive Standard Health Benefit Plan (CSHBP) in Maryland's Small Group Market,"* to calculate cost projections through 2004 on these proposed changes.

Mercer's resulting document, entitled *"Initial Review of Public Comment on the Maryland Health Care Commission (MHCC) Comprehensive Standard Health Benefit Plan (8/18/03),"* was the basis for discussion at the August 21st meeting. At the conclusion of that meeting, participants were asked to resubmit recommended changes to the plan in an effort to reach 90% of the projected cap, or a cost reduction of 21.6%. It should be noted that in the Mercer document dated 8/18/03, Mercer was asked to compare the type and extent of benefit coverage in the small group market with large group and self-funded markets in Maryland. As a result of that analysis, four areas were identified where benefits in the small group market exceeded other coverages. Elimination of or a reduction in the following benefits and their associated savings are as follows: chiropractic services (2.0%); mental health and substance abuse (0.5%); habilitative services for children (minimal); hearings aids for children (0.1%). It was the consensus of the stakeholders present at the August 21st meeting that these benefits should not be reduced. No other benefit reductions, other than pharmacy, were suggested. At that time, all stakeholders present at the meeting supported separating the pharmacy benefit from the CSHBP and making it a required offering.

Staff received written comments from the following interested parties:

- Miles Cole, Senior Vice President of Government Affairs, Maryland Chamber of Commerce
- Linda Cooper, Government Relations Director, Aetna, Inc.
- Elizabeth P. Sammis, Ph.D., Senior Vice President, Corporate Communications and External Affairs, Mid-Atlantic Medical Services, Inc. (MAMSI)
- Lynda Sussman, Executive Vice President, C.O.B., Inc.
- CareFirst BlueCross BlueShield

Staff developed the following recommendations based on Mercer's projections and input from interested parties.

In addition, when considering cost-sharing changes to the CSHBP, staff referred to Insurance Article § 15-1207(g)(2) and (3):

> "…the Commission shall:…balance the effect of cost-sharing in reducing premiums and in affecting utilization of

appropriate services; and …limit the total cost-sharing that may be incurred by an individual in a year."

Finally, staff believes it is important to stress that the original charge to the Commission is to offer coverages that are typically provided by Maryland employers (both insured and self-funded companies), while also meeting the minimum requirements of a federally qualified HMO.

For these reasons, Commission staff recommended the following two scenarios as proposed changes to the CSHBP:

Scenario #1	**Reduction (-)/ Increases (+)**
Services Reductions	
None	0.0%
Pharmacy Changes	
Remove the prescription drug benefit from the CSHBP and make the current pharmacy benefit a required offering (by rider) by carriers	- 12.9%
Require a Pharmacy Discount Card	+ minimal
Cost Sharing Changes	
Increase the emergency room copay from $35 plus coinsurance to $100 plus coinsurance ***OR*** Increase the emergency room copay from $35 plus coinsurance to $200 plus coinsurance	Increase to $100 = - 1.0%. Increase to $200 = - 2.5%
Increase the PPO deductible to $2,500 from $1,000 ($5,000 per family) – increase the out-of-pocket max accordingly	- 9.4%
Increase the POS deductible to $1,000 from $400 ($2,000 per family) – increase the out-of-pocket max accordingly	- 0.6%
Increase the Indemnity deductible to $2,500 from $1,250 ($5,000 per family) – increase the out-of-pocket max accordingly	- minimal
Increase copays for skilled nursing facilities, radiology, pathology, outpatient therapy, and outpatient surgery so that they are in line with the HMO specialist copay of $30	- 1.1%
On the HMO, increase the PCP copay from $20 to $30 and the specialist copay from $30 to $40 ***OR*** Increase the PCP copay from $20 to $40 and the specialist copay from $30 to $50	$10 increase = - 0.8% $20 increase = - 1.5%
Total	- 25.8% to - 28.0%

Highlights of Scenario 1:

- Adopting all of the recommendations under Scenario 1 would result in an estimated premium reduction of between 25.8% and 28.0%.

- Removing the prescription drug benefit from the CSHBP and making it a separately priced required offering would reduce the overall CSHBP premium about 13%. Staff also recommends that participating carriers be required to sell this required offering on a guaranteed issue basis with at least the existing prescription drug benefit. Carriers could offer employers more choice with alternative prescription coverage offerings. This would allow carriers to continue participating in the small group market without having to make any changes to their drug program if they elect not to offer alternative prescription drug options. The advantage of this option is to allow carriers to price pharmaceutical coverage more competitively. Pharmacy benefit design is one area where innovation is occurring to drive cost-effective use of generic drugs. Also, by separating pharmacy costs from other benefits, employers would become more aware of these costs and how to manage them.

- Scenario 1 recommends an increase in the PPO deductible from $1,000 to $2,500 for an individual and from $2,000 to $5,000 for a family. This change is also in response to requests to allow more choice to employers because it would also allow employers/carriers to offer employees a Health Reimbursement Arrangement (HRA) or other type of consumer driven health plan. This change permits more flexibility in benefit design.

- The recommendation to increase deductibles in the indemnity and POS delivery systems should help maintain some competitiveness among all delivery systems.

- The final recommendation under Scenario 1 is to increase copayments and coinsurance for specific covered services, as suggested by stakeholders. Collectively, these proposed changes amount to a premium reduction between 1.9% and 2.6%.

Scenario #2	**Reduction (-)/ Increases (+)**
Services Reductions	
None	0.0%
Pharmacy Changes	
Maintain the generic copay at $15 and adopt a 20% coinsurance for Tier 2 (brand name formulary) and a 50% coinsurance for Tier 3 (brand name non-formulary)	Minimal initial cost impact but future premium increases would be reduced
Cost Sharing Changes	
Increase the emergency room copay from $35 plus coinsurance to $100 plus coinsurance ***OR*** Increase the emergency room copay from $35 plus coinsurance to $200 plus coinsurance	Increase to $100 = - 1.0%. Increase to $200 = - 2.5%
Increase the PPO deductible to $2,500 from $1,000 ($5,000 per family) - increase the out-of-pocket max accordingly	- 9.4%
Increase the POS deductible to $1,000 from $400 ($2,000 per family) – increase the out-of-pocket max accordingly	- 0.6%
Increase the Indemnity deductible to $2,500 from $1,250 ($5,000 per family) – increase the out-of-pocket max accordingly	- minimal
Increase copays for skilled nursing facilities, radiology, pathology, outpatient therapy, and outpatient surgery so that they are in line with the HMO specialist copay of $30	- 1.1%
On the HMO, increase the PCP copay from $20 to $30 and the specialist copay from $30 to $40 ***OR*** Increase the PCP copay from $20 to $40 and the specialist copay from $30 to $50	$10 increase = - 0.8% $20 increase = - 1.5%
Total	- 12.9% to - 15.1%

Highlights of Scenario 2:

- Adopting all of the recommendations under Scenario 2 would result in an estimated premium reduction of between 12.9% and 15.1%.

- The prescription drug option under Scenario 2 maintains the prescription drug benefit as a required benefit in the CSHBP, but replaces the $20 copay on preferred brand name or "tier 2" drugs with a 20% coinsurance, and replaces the $30 copay on non-preferred brand name or "tier 3" drugs with a 50% coinsurance. The existing copay on generic or "tier 1" drugs would remain at $15. Estimated cost reductions, if any, would depend on the change in utilization among all three tiers within the formulary. The initial cost impact on the overall cost of the CSHBP is projected to be minimal but future premium increases would be reduced, as utilization shifts from Tier 3 drugs to less expensive drugs.

- The remaining cost sharing changes under Scenario 2 are the same as those under Scenario 1 (i.e., increasing various deductibles, copayments, and coinsurance).

Public Hearings: This year, the Commission chose to present these recommendations for comment at two public hearings. The first hearing was held in Annapolis on September 23, 2003 before the Senate Finance Committee and the House Health & Government Operations Committee. At this hearing, Commission staff updated the committees on the nature of the problem in the small group market, the impact of SB 477, and the process the Commission staff followed in developing these recommendations. The committees were briefed on the recommendations included in both Scenario #1 and Scenario #2. Then, public testimony was presented by the following interested parties:

Eric Gally – Maryland Citizens' Health Initiative ("Health Care for All!")
Tonya Vidal Kinlow – Kaiser Permanente of the Mid-Atlantic States (Kaiser)
Elizabeth P. Sammis, Ph.D. – Mid-Atlantic Medical Services, Inc. (MAMSI)
Miles Cole – Maryland Chamber of Commerce
Bryson Popham – National Association of Health Underwriters
Fran Doherty – CareFirst BlueCross BlueShield of Maryland (CareFirst)

The Maryland Citizens' Health Initiative spoke in opposition to both scenarios and urged the Commission to make no changes to the CSHBP until the General Assembly hears their global proposals on universal health care during the 2004 legislative session.

Kaiser testified in support of Scenario #1 as long as criteria are established for a minimum level of prescription drug benefits so that carriers cannot carve out particular types of prescription drugs.

MAMSI testified in support of Scenario #1 but did not support the implementation of a prescription drug discount card. Dr. Sammis suggested an additional change to the plan: divide the existing emergency room copay between the emergency room physician and the facility. MAMSI also supports the inclusion of mail order prescription drugs with varying copays between mail order and retail prescription drugs. Dr. Sammis noted that MAMSI believes it is not necessary to implement a 20% coinsurance on brand name formulary (tier 2) and brand name non-formulary (tier 3) drugs since the CSHBP currently includes an ancillary charge between generic drugs (tier 1) and tier 2 and tier 3 drugs. Dr. Sammis concluded her testimony by stating that MAMSI supports flexibility

in the small group market that mimics flexibility in the large group market along with the concept that consumers be more conscientious about their health care choices.

The Maryland Chamber of Commerce testified in support of Scenario #1, stating that the marketplace will have a faster, more positive impact on human behavior in terms of health care choices than a Commission-set standard. Mr. Cole also noted that allowing for HRAs in the small group market will offer more choice to consumers. He concluded that prescription drug discount cards already exist in health care markets other than the small group market.

Mr. Popham stressed the importance of bringing more carriers into the small group market to create more competition. He commended Commission staff on the process taken in addressing the problems in the small group market and including all relevant stakeholders in the process. He also agreed to continue working with staff throughout this process.

On behalf of CareFirst, Ms. Doherty urged the Commission to proceed with the recommendations under Scenario #2. She encouraged more competition and offering more choice to consumers. She also commended Commission staff on its work.

The second public hearing was held at the MHCC offices in Baltimore on October 2, 2003. The following interested parties testified at this hearing:

Panel #1:	Ellen Valentino – National Federation of Independent Business
	Jeff Levin – small employer – Field's of Pikesville
Panel #2:	Miles Cole – Maryland Chamber of Commerce
	William Chambers – Chairman, Maryland Chamber of Commerce
	Fred Teeter – Hagerstown Chamber of Commerce
	Wayne Barnes – Carroll County Chamber of Commerce
Panel #3:	Lynda Sussman – C.O. B., Inc. (insurance broker)
	Andrea Bounocontro – Maryland Centers for Independent Living
Panel #4:	Glenn Schneider and Bishop Douglas Miles – Maryland Citizens' Health Initiative
Panel #5:	Eric Gally – American Cancer Society and American Heart Association
	Bonita Pennino – American Cancer Society
Panel #6:	Jan Schmidt – Advocates for Children and Youth
	Kevin Stayton – Public Justice Center

Ms. Valentino and Mr. Levin testified in support of Scenario #1, both stating that it would provide more health care options to small employers in Maryland.

Panel #2, representing various chambers of commerce in the state, also supported Scenario #1 because it would allow consumers more choice and create more flexibility in the small group market.

Ms. Sussman, an insurance broker, and Ms. Buonocontro, a client of C.O.B., emphasized the importance of the provisions of small group market reform, such as guaranteed issue, guaranteed renewal, and no pre-existing condition limitations. She also noted that flexibility in a group insurance plan is essential to small employers.

Panel #4 spoke on behalf of the Maryland Citizens' Health Initiative. This group did not support either scenario and urged the Commission to take as little action as possible this year in order to comply with the law (i.e., not exceed the 10% affordability cap) and to allow their organization the opportunity to present their global proposals to the General Assembly during the 2004 legislative session. Panel #5, speaking on behalf of the American Cancer Society and the American Heart Association, provided testimony similar to Panel #4.

Ms. Schmidt testified in an effort to bring a consumer's voice to the Commission. She believes that the staff recommendations go beyond the Commission's legislative mandate. She and Mr. Stayton spoke in opposition of both scenarios. Specifically, Ms. Schmidt opposed raising the deductibles because that change could result in many insured individuals not seeking needed care because of high out-of-pocket costs. She also testified in opposition to the inclusion of HRAs because that change could lead to cost shifting and reduced utilization.

Alternative Staff Recommendations: After the public hearings, Commission staff met with its consulting actuary and MIA staff to review all testimony and develop additional alternatives for keeping the overall cost of the CSHBP below the 10 percent cap while maintaining a comprehensive, affordable benefits package. After much discussion, Mercer was asked to project the cost impact of additional changes to the plan, such as different copay and/or deductibles across all delivery systems, various copays for specific services, and other options for the prescription drug benefit. As a result, Commission staff has modified its recommendations originally outlined in Scenario #1 and Scenario #2 and has developed the following recommended changes to the CSHBP.

After giving serious consideration to all the testimony heard and given that the reported 2002 composite premium did not exceed the affordability cap, staff is now recommending that the CSHBP only be modified to meet the minimum projections of 100% of the projected cap, rather than 90% of the projected cap. Therefore, keeping the prescription drug benefit in the CSHBP rather than carving it out and making it a required offering will allow this goal to be met.

Several stakeholders made compelling arguments in support of carving out the prescription drug benefit from the CSHBP, such as providing more flexibility and more consumer choice. However, carving it out also could lead to adverse selection in the small group market, since only those needing this benefit would buy it, causing premiums to increase for those remaining in the small group market. Many other interested parties, as well as Commission staff, believe that prescription drug coverage is one of the most important benefits to consumers and should remain in the benefits package so that it remains a comprehensive health care plan. The savings created by keeping this benefit in

the CSHBP while increasing copays is projected to be adequate to keep the overall cost of the plan within the affordability cap for one more year.

Alternatives for the Prescription Drug Benefit:

A. Maintain the existing prescription drug benefit in the CSHBP but increase the out-of-pocket costs as follows:

Deductible:	maintain the $250 per person deductible.
Copays:	Tier 1 (generic drugs) – maintain the existing $15 copay per prescription. Tier 2 (brand name formulary drugs) – Replace the existing $20 copay with a 20% coinsurance. Tier 3 (brand name non-formulary drugs) – Replace the existing $30 copay with a 50% coinsurance.

For a 90-day supply of a maintenance drug, apply the following:

Tier 1:	Maintain the existing $30 copay
Tier 2:	Replace the existing $40 copay with a 20% coinsurance
Tier 3:	Replace the existing $60 copay with a 50% coinsurance.

This option mirrors the prescription benefit change under Scenario #2. The initial cost impact on the overall cost of the CSHBP is projected to be minimal but future premium increases would be reduced, as utilization shifts from Tier 3 drugs to less expensive drugs.

B. Same option outlined above except for Tier 3: replace the existing $30 copay with a 20% coinsurance, subject to a $1,000 deductible.

The basis for this option is a result of the cost savings depicted in the following example: For an insured individual who has leukemia and requires a brand name non-formulary drug that costs $30,000, alternative A would cost this person $15,000. Under alternative B, the drug would cost this person the $1,000 deductible and then 20% of $29,000 totaling $6,800; less than one-half the cost under alternative A.

Mercer projects this option would **increase** the prescription drug benefit by about 21%, which in turn would **increase** the composite CSHBP premium by about 2.7%.

C. Maintain the existing prescription drug benefit in the CSHBP but increase the out-of-pocket costs as follows:

Deductible:	maintain the $250 per person deductible.
Copays:	Tier 1 (Generic): maintain the existing $15 copay

Tier 2 (Brand Name Formulary): increase the existing $20 copay to $25
Tier 3 (Brand Name Non-Formulary): increase the existing $30 copay to $50

For a 90-day supply of a maintenance drug, apply the following:

Tier 1:	Maintain the existing $30 copay
Tier 2:	Increase the existing $40 copay to $50
Tier 3:	Increase the existing $60 copay to $100.

Commission staff recommended Option C for pharmacy benefit modification.

With this option, the existing copayment regulations would not change; i.e., when a brand name formulary or non-formulary (i.e., Tier 2 or Tier 3) drug is dispensed but a generic drug is available, the beneficiary would be required to pay the applicable copay plus the difference between the cost of the Tier 2 or Tier 3 drug and the cost of the generic drug.

Mercer projects that these increases in copays would create an overall cost reduction on the composite CSHBP premium of about 1%.

Staff Recommendations Presented to Commission on Modifications to the CSHBP:

A. Emergency Room Copays: Increase the emergency room copay from $35 plus the coinsurance to $100 plus the coinsurance.

As a result of the stakeholder meetings and the public hearings, it became evident that emergency room utilization in Maryland hospitals is increasing rapidly across all health care markets. Public testimony revealed that the current $35 copay provides little incentive for individuals to utilize less costly health care settings, such as a doctor's office or an urgent care center. If an emergency room visit results in an inpatient admission, the copay is waived and becomes an inpatient charge subject to the individual's existing policy. Mercer estimates increasing this copay from $35 to $100 could reduce the overall cost of the CSHBP by 1.0%.

B. PPO deductibles: Increase the PPO deductible from $1,000 to $2,500 per individual and from $2,000 to $5,000 per family, with corresponding increases in the out-of-pocket maximum, from $3,400 to $4,900 per individual and from $6,800 to $9,800 per family.

Mercer estimates this change should reduce the PPO premium by about 22% which in turn should reduce the average CSHBP premium by approximately 9.4%.

C. POS deductibles: Increase the POS deductible from $400 to $1,000 per individual and from $800 to $2,000 per family, with corresponding increases in

the out-of-pocket maximum, from $2,500 to $3,100 per individual and from $5,000 to $6,200 per family.

Mercer estimates this change should reduce the POS premium by about 9% which in turn should reduce the composite premium by about 0.6%.

D. Indemnity deductibles: Increase the indemnity deductible from $1,250 to $2,500 per individual and from $2,500 to $5,000 per family, with corresponding increases in the out-of-pocket maximum, from $3,500 to $4,900 per individual and from $7,000 to $9,800 per family.

Mercer estimates this change should reduce the indemnity premium by about 18%. Because so few enrollees remain in this delivery system, the composite premium would be reduced by less than 0.1%.

E. HMO copays: Increase the HMO copay for a PCP visit from $20 to $30, and increase the HMO copay for a specialty care visit from $30 to $40.

Mercer estimates that this change will reduce the HMO premium by 1.5%, which in turn should reduce the composite CSHBP premium by 0.8%.

F. Other copays: Increase copays for skilled nursing facilities, radiology, pathology, outpatient therapy, and outpatient surgery to be in line with the HMO specialist copay of $40.

Commission staff recommended this change with the understanding that the increased copay remain subject to the existing conditions; i.e., that the insured is responsible for the copay or an applicable coinsurance, whichever is greater, for all delivery systems except for the HMO. For the HMO, the copay would be increased from $20 to $40.

Mercer projects this change would produce an estimated premium reduction of approximately 2.1%.

Commission Final Action: At the October 30th public meeting, the Commission approved the staff recommendations for adoption into the CSHBP, with one dissenting vote. The dissenting vote was based on the prescription drug benefit. That commissioner supported the removal of the prescription drug benefit from the CSHBP and making it a mandated offering, rather than increasing the copays for Tier 2 and Tier 3 drugs.

In summary, the approved modifications and their projected cost impact on the overall premium of the CSHBP are as follows:

Projected Ratio of Premium Rate to Rate Ceiling by 2004:	**114.8%**
<u>Laws passed that directly impact CSHBP</u>	
None	0.0%
<u>Mandates passed that do not affect CSHBP</u>	
Coverage for Home Visits after Mastectomy or Surgical Removal of a Testicle - Extension of Sunset (SB 39): no action – benefit already in place	0.0%
<u>Proposed mandates that failed/withdrawn</u>	
Payments to Providers for Colorectal Cancer Screening (HB 569): no action;	0.0%
Coverage for Ovarian Cancer Screening (HB 670): no action	0.0%
<u>Stakeholder Requests</u>	
In Vitro Fertilization: no action	0.0%
<u>Modifications to Cost-Sharing Arrangements</u>	
Prescription Drug Coverage: maintain the generic copay of $15; increase the copay for Tier 2 drugs from $20 to $25; and increase the copay for Tier 3 drugs from $30 to $50	- 1.0%
Increase the emergency room copay from $35 to $100	- 1.0%
Increase the PPO deductible to $2,500/individual and $5,000/family	- 9.4%
Increase the POS deductible to $1,000/individual and $2,000/family	- 0.6%
Increase the Indemnity deductible to $2,500/individual and $5,000/family	0.0%
Increase the HMO PCP copay from $20 to $30 and the HMO specialist copay from $30 to $40	- 0.8%
Increase the special services copay to be in line with the specialist copay	- 2.1%
Projected Premium Reduction:	-14.9%
Projected Ratio of Premium Reduction after Changes are Implemented:	**99.9%**

The proposed regulations based on the Commission action have been published in the <u>Maryland Register</u>, subject to a 45-day comment period. The Commission will take final action at the February or March 2004 public meeting. All adopted changes to the CSHBP will be put into regulations and implemented, effective July 1, 2004.

APPENDIX A

Change	*Effective Date*	*Reason for Considering this Change*	*Estimated Cost Impact on CSHBP*
Require carriers to include the self-employed as a small employer in the CSHBP	July 1, 1996	Law	0.60%
Extend $10 copay for well-child visits for immunizations for children 2 to 18 years	July 1, 1996	Stakeholder request	
Require carriers to follow the most recent edition of the "Guide to Clinical Preventive Services"	July 1, 1996		
Add a triple option POS delivery system	July 1, 1996	Stakeholder request	
Replace the sliding scale for outpatient rehab services with a flat 70% coinsurance in-network/50% out-of-network for the carrier, or a $20 copay	July 1, 1996	Stakeholder request	
Specify a max of 30 visits per therapy per condition per year for outpatient rehab services and allow federally-qualified HMOs to maintain 60 consecutive days for such services	July 1, 1996	Stakeholder request	
Expressly permit carriers to offer, as an additional service through a rider, coverage for Christian Science practitioners and facilities	July 1, 1996	Stakeholder request	
Count a visit for medication management as a physician visit rather than a mental health visit	July 1, 1996	Stakeholder request	0.00%
Require carriers to provide for a 48-hour maternal/newborn hospital stay after vaginal birth and 96-hour stay after C-section	July 1, 1996	Mandate enacted (SB 433/HB 1271); no direct impact on CSHBP	0.80%
Require carriers to provide coverage for medical screening services in an emergency room facility	July 1, 1996	Mandate enacted (HB 615); no direct impact on CSHBP	0.10%
Extend $10 copay for well-child visits for immunizations for children 0 to 13 years and eliminate the deductible	July 1, 1997	Stakeholder request	0.10%
Provide coverage for breast reconstructive surgery	July 1, 1997	Mandate enacted, effective Oct. 1, 1996 (HB 119)	<0.05%
Expand coverage for diabetic equipment to include coverage for syringes and needles under the Rx coverage and glucose monitoring equipment and supplies under DME	July 1, 1997	Mandate proposed but not enacted (SB 49/HB 227)	<0.05%
Add PEOs to the small group market*	Oct. 1, 1997	Law (HB 213)	0.00%
Allow insureds to receive up to a 90-day supply of a maintenance drug at a single dispensing*	Oct. 1, 1997	Law (HB 368)	0.10%
Add a high deductible PPO/MSA delivery system to the CSHBP*	Oct. 1, 1997	Law (HB 843)	- 0.2%
Require carriers to disclose the definition of experimental medical care	July 1, 1998	Mandate enacted (SB 163); no direct impact on CSHBP	0.00%
Require coverage for prostate cancer screening for men between 40 and 75 years	July 1, 1998	Mandate enacted (SB 428); no direct impact on CSHBP	<0.05%
Require HMOs to offer a mandatory POS option	July 1, 1998	Mandate enacted (SB 433/HB 831); no direct	0.00%

* This mandate directly affects the CSHBP.

		impact on CSHBP	
Change	***Effective Date***	***Reason for Considering this Change***	***Estimated Cost Impact on CSHBP***
Establish eligibility for coverage for individuals for whom guardianship is granted	July 1, 1998	Mandate enacted (HB 729); no direct impact on CSHBP	0.00%
Require certification of eligible coverage	July 1, 1998	Mandate enacted (HB 843); no direct impact on CSHBP	0.00%
Increase indemnity and PPO cost sharing arrangements	July 1, 1998	Stakeholder request	- 4.50%
Specify coverage for nebulizers & peak flow meters as DME	July 1, 1998	Stakeholder request	<0.05%
Change reimbursement for chiropractic services to 70% in-network and 50% out-of-network	July 1, 1998	Stakeholder request	0.00%
Clarify direct access to OB/GYN care	July 1, 1998		0.00%
Provide for a 90-day supply of a maintenance drug at a single dispensing, except for new prescriptions or changes in prescriptions	July 1, 1999	Mandate enacted (HB 173/SB 235); no direct impact on CSHBP	- 0.05%
Require coverage for prescription contraceptive drugs or devices	July 1, 1999	Mandate enacted (HB 457/SB 335); no direct impact on CSHBP	<0.05%
Require coverage for general anesthesia for dental care under specified conditions	July 1, 1999	Mandate enacted (SB 479); no direct impact on CSHBP	<0.05%
Require carriers to reimburse practitioners for oncology drugs given in a physician's office	July 1, 1999	Mandate enacted (SB 643); no direct impact on CSHBP	<0.05%
Require coverage for one routine audiology screening and one confirming screening for all newborns	July 1,1999	Mandate proposed but not enacted	0.10%
Increase coverage for mental health inpatient services from 25 to 60 days	July 1, 1999	Stakeholder request	0.20%
Provide coverage for domestic partners in the CSHBP	July 1, 1999	Stakeholder request	0.00%
Require carriers to provide for extension of benefits if coverage is terminated in the midst of treatment or hospitalization for a specified period*	Oct. 1, 1999	Law (SB 67)	<0.05%
Apply provisions of the Governor's *"Patients' Bill of Rights Act"*	Nov. 1, 1999	Mandate enacted (HB 182); no direct impact on CSHBP	<0.05%
Require HMOs that approve emergency services by a non-network provider to reimburse the provider for medically necessary follow-up care*	July 1, 2000	Law (SB 475/HB 576)	<0.05%
Require carriers to cover annual chlamydia screenings	July 1, 2000	Mandate enacted (HB 46); no direct impact on CSHBP	<0.05%
Repeal provisions of the law relating to reimbursement of practitioners for oncology	July 1, 2000	Repeal enacted (HB 280); no direct impact on CSHBP	0.00%
Implement a prescription drug formulary	July 1, 2000	Stakeholder request	- 2.00%
Increase deductibles in the PPO delivery system	July 1, 2000	Stakeholder request	- 1.00%

* This mandate directly affects the CSHBP.

Change	*Effective Date*	*Reason for Considering this Change*	*Estimated Cost Impact on CSHBP*
Modify the determination of employer group size as it relates to the small group insurance market*	July 1, 2000	Law (SB 801/HB 649)	<0.05%
Require HMOs to pay claims for covered services that are provided by a health care provider who is not under written contract with the HMO*	July 1, 2001	Law (SB 405/HB 365)	0.10%
Provide access to OB/GYN services	July 1, 2001	Mandate enacted (SB 567/HB 669); no direct impact on CSHBP	<0.05%
Provide a standing referral to an obstetrician for pregnancy	July 1, 2001	Mandate enacted (HB 316); no direct impact on CSHBP	<0.05%
Provide coverage for colorectal cancer screening	July 1, 2001	Mandate proposed but not enacted	0.10%
Increase deductibles in the indemnity, PPO, and POS delivery systems	July 1, 2001	Stakeholder request	-4.40%
Increase the prescription drug deductible from $150 to $250 per person	July 1, 2001	Stakeholder request	-1.20%
Increase the HMO copay from $10 to $20 for a primary care visit, and from $20 to $30 for a specialty care visit	July 1, 2001	Stakeholder request	-1.60%
Include a $250 deductible per inpatient hospital admission for HMO plans	July 1, 2001	Stakeholder request	-1.20%
Provide coverage for hearing aids for children, limited to minor children ages 0 to 18 years	July 1, 2002	Law (HB 160)	0.10%
Provide coverage for residential crisis services	July 1, 2003	Mandate enacted (HB 896); no direct impact on CSHBP	<0.05%
Grand Total of Estimated Cost Impact of Each Added Benefit			3.05%
Grand Total of Estimated Cost Impact of Each Cost-Sharing Adjustment			-16.15%
		Net Impact of All Changes	-13.10%

* This mandate directly affects the CSHBP.

III. Report on the Feasibility of a Basic Plan

Report on the Feasibility of a Basic Plan

Under Chapter 93 of the 2003 Laws of Maryland (SB 477), the Maryland Health Care Commission is required to study the feasibility of creating a Basic Plan in addition to the Standard Plan in the small group market.

Overview

The MHCC is currently charged with designing the Comprehensive Standard Health Benefit Plan (CSHBP), which is the minimum plan that carriers in the small group market must sell to small employers. The design of the CSHBP includes the benefits that must be covered and specifies cost-sharing arrangements. The current minimum benefits of the plan must be the actuarial equivalent of the minimum benefits required to be offered by a federally qualified HMO. The cost of the CSHBP may not exceed 10% of the State's average annual wage.[1]

Legislation was introduced this year that would have required the Maryland Health Care Commission (MHCC) to develop a basic health benefit plan for employers with two to 50 employees and self-employed individuals.[2] The cross-filed bills, which did not specify a minimum set of benefits, stated that the premium of a basic plan could not exceed a certain percentage of the State's average annual wage (House bill proposed 6% and Senate bill proposed 8%). While both House and Senate versions of this legislation did not pass, legislation enacted during this year's session requires MHCC to study the feasibility of offering a basic plan in the small group market.

One possible design for a basic plan is **catastrophic coverage**. Without a change to current law, catastrophic coverage would have to include the value of the benefits that are required to be offered by a federally qualified health maintenance organization (FQHMO). Catastrophic plans generally cover major hospital and medical expenses and include relatively high deductibles that must be met before the carrier pays for expenses. A catastrophic plan does not provide first-dollar coverage for routine visits to doctors or prescription drugs, requiring the enrollee to pay for these services out-of-pocket until the deductible is met. Commission action at its October 30th public meeting created a high deductible PPO plan within the CSHBP benefit design structure. Deductibles in the CSHBP can now be as high as $2,500 for an individual and $5,000 for a family. However, once deductibles are met, coverage is comprehensive.

Another type of basic plan that a growing number of employers are offering to low-income employees is a **limited benefit plan**. Under this type of plan, employees, for example, could pay a lower premium for specified reimbursement of everyday medical care expenses, such as doctor visits. A much lower deductible is usually required to be met before benefits are paid by the insurer. These plans may limit a carrier's annual exposure in medical expenses; under some limited benefit plans, hospitalization and other major medical expenses are limited in reimbursement, if covered at all.[3] A "fixed indemnity" product is a type of limited benefit plan.

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[1] Senate Bill 477, *Small Business Health Insurance Affordability Act*, reduced the cap from 12% to 10%.
[2] House Bill 627/Senate Bill 382, *Health Insurance – Small Group Market – Basic Health Benefit Plan.*
[3] Terhune C. "Fast-growing health plan has a catch: $1,000-a-year cap." *Wall Street Journal.* 14 May 2003.

Fixed indemnity plans are a type of insurance that, for example, pays a certain dollar amount for each day a policyholder is in the hospital (e.g., $100 per day) or for a physician office visit (e.g., $30 per visit). Most of these policies have a limit on the number of hospital days (e.g., maximum 100 days) or the number of office visits (e.g., 5 visits per year). Fixed indemnity products are different from expense-incurred insurance policies where the benefits are related to the expenses policyholders actually incur when they receive services. Currently, fixed indemnity products do not fall within the definition of the health plans that are governed by the requirements of the small group market.

The difference between these two approaches to benefit design can be characterized as either: (1) access promotion, a system that encourages early diagnosis through routine health care in order to increase the potential for better outcomes of treatment and reduced costs; or (2) asset protection, which uses copays and deductibles to shift some of the up-front cost of low-cost care to the consumer, while providing the individual protection from losing assets due to a catastrophic event.[4] Identifying the target population of a basic benefit plan will guide which of these two approaches is more appropriate. A very low-income uninsured population would be unlikely to purchase a catastrophic plan as they could not afford the required out-of-pocket costs that would accompany such a plan. Moreover, it is less likely that a low-income individual would need asset protection and costly hospitalization would be covered through the all-payor system's provisions for uncompensated care.

Issues to be Considered in Determining the Feasibility of Creating a Basic Plan

- Increased Affordability and Access: The average cost of a basic health benefit plan would be lower than the CSHBP because of its more limited coverage. Employers and their employees who currently cannot afford to obtain and maintain health insurance coverage through the Standard Plan for themselves and their dependents may be able to purchase a basic benefit plan. This increased access to health care could, in turn, help to improve the quality of health of these individuals.

- Risk-Segmentation: The availability of a basic health benefit plan in the small group market could encourage risk segmentation in that market. A plan offering fewer benefits and greater cost-sharing arrangements for employees is likely to be primarily marketed to and chosen by employers who have relatively healthy or young employees. Less healthy or older employees will need and choose the CSHBP (or a plan which is even more enhanced) which has more comprehensive benefits and lower out-of-pocket costs. By segregating the low-risk employees from the higher-risk employees, the healthier employees would no longer be part of the shared-risk pool and no longer help to subsidize less healthy or older employees – this could cause the small group market to deteriorate. Any limited benefit plan may need to offer substantially less benefits than the Standard Plan to discourage this potential adverse selection.

  If this risk segmentation occurred, premiums in the CSHBP would have to increase in order to cover the claims of the smaller, less-healthy, and older pool. Increasing

[4] "Issues Involved in Designing a Basic Benefit Package and Determining Actuarial Equivalence," http://www.statecoverage.net/statereports/or10.pdf

premiums for those with the greatest health and financial needs for insurance will inevitably lead to a portion of these individuals opting to go without health coverage or employers dropping coverage. – perhaps causing an adverse selection "death spiral."

- Limited Competition: It has been argued that a basic health benefit plan with a value that is less than the actuarial equivalent of the benefits covered by a federally-qualified HMO (FQHMO) could not be sold by FQHMOs and, thus could lead to less competition in the potential market for limited benefit plans. However, according to the federal Centers for Medicare and Medicaid Services (CMS), an FQHMO may establish and operate separate non-Federally qualified lines of business.[5] These products would still be subject to state requirements.

- Effects of Benefits under a High-Deductible Catastrophic Plan: A basic plan that is essentially a catastrophic plan would likely cover only major hospital and medical expenses and include high deductibles. The enrollee would pay out-of-pocket for doctor's office visits and other preventive care benefits, including prescription drugs. For lower-income employees and their families, the need to pay upfront for covered benefits (before the deductible has been met) and those benefits not included in a basic plan could be prohibitively expensive. Research has shown that even with minimal cost-sharing, low-income consumers might forego needed primary and preventive care. Benefit plan design with some first-dollar preventative care could mitigate this problem.

- Effects of Benefits under a Limited Benefit Plan: Individuals enrolled in a limited benefit plan may not be able to obtain needed health care services if the plan does not provide coverage or adequate coverage for a particular condition or they exceed coverage limits. This could lead to poorer health outcomes among these individuals than if they had comprehensive coverage. However, if the individuals opting for a limited benefit plan had previously been uninsured, then some benefits could arguably be better than no benefits, especially if certain preventative benefits were covered.

- Past Experience Shows Basic Benefit Plans are Unpopular: Basic plans, especially catastrophic plans, typically have not been popular, as small employers seem to want to offer comprehensive benefits similar to large employers. However, limited benefit plans are currently the fastest-growing health insurance offerings in the workplace, due in large part to the economic downturn and increasing health care expenses.[6]

- Employees Lose Choice of More Comprehensive Plan: If employers selected only a basic health plan for cost reasons, then their employees would be subject to that decision, unless they bought a more comprehensive plan on their own without the benefit of pretax dollars.

[5] Operational Policy Letter #22, Heath Care Financing Administration (now CMS), December 9, 1994.
[6] Terhune C. "Fast-growing health plan has a catch: $1,000-a-year cap." *Wall Street Journal.* 14 May 2003.

Potential Plan Designs

Mercer, the Commission's actuarial consultant, provided some actuarial estimates for premiums under a number of limited plan designs including:

- Federally Qualified HMOs which is the current floor for the CSHBP
- The Limited-benefit plan similar to plan in law in the early 1990's[7]
- Benefit Plan similar to that offered under the Healthy NY plan
- Rhode Island Standard and Economy health benefit plans
- Limited Benefit Plan developed under the Community Access Program grant received by the Western Maryland Health System

Mercer's actuarial estimates for these limited plan designs, relative to the new benefit levels that have been adopted for the CSHBP effective July 2004, show a range of values between 60% and 95% of the Standard Plan, with an average falling around 80%. Much of the savings projected (12% - 13%) comes from the exclusion of pharmacy benefits in these limited benefit plans.

Questions to be Addressed

A number of questions were posed when the issue brief on the feasibility of a basic plan was released for public comment. Comments made at the public meeting and received in writing were more general in nature and did not address many of the more specific questions outlined below.

1. Who is the target audience of the basic health plan? And, how will that affect what should be the benefit structure of the basic plan? For example, looking at groups of small employers with employees with wages that fall between 100%-200% of poverty, 201%-300% of poverty, and 301%-400% of poverty, as the income scale increases, it is more likely that a catastrophic plan would be appealing while, at the low-wage end of the scale, a limited benefit plan with first dollar coverage or at least lower deductibles may be more attractive.

2. What services should be included in or excluded from the basic plan (e.g., preventative care, comprehensive primary care, urgent and emergent hospital and surgical care, mental health integration, etc.)?

3. Should riders be prohibited? It is a concern that riders for additional services could be bought to bring the basic health plan to just under the CSHBP, which leads to the

[7] In 1991, legislation was enacted that allowed a limited benefit plan to be sold in Maryland by all insurers, nonprofit health service plans and HMOs. The law was relatively explicit in the parameters of the benefit design. Eligibility was restricted to individuals and families who had not been covered by health insurance during the preceding year, and to small employer groups who had not had health insurance coverage for the preceding two years. Only Blue Cross Blue Shield of Maryland actually solicited the sale of the limited benefit plan and, by the end of 1992, there were 166 policies in place. The limited benefit plan legislation was allowed to sunset June 30, 1994 (Report to the General Assembly on limited benefit plans from the Maryland Insurance Administration. July 28, 1993).

question of what would be the point of having the CSHBP? One option is to allow riders to decrease the copays and deductibles but not allow riders to increase the services in the plan.

4. Should a basic benefit plan only be available to those employers who had not offered coverage during a certain defined past (e.g., no benefits offered during the past 24 months)?

5. Should the basic benefit plan be designed with a floor and a ceiling so that carriers can be creative within those parameters (e.g., a floor that requires a minimum of 10 days of inpatient hospital coverage and a ceiling that allows a maximum of 30 days inpatient hospital coverage)?

6. Should the same protections that apply to the CSHBP apply to the basic plan? These protections include guaranteed issue and renewal, and no medical underwriting. Should a limited period to rate for pre-existing conditions be allowed for newly enrolled groups without previous coverage?

7. Should there be a limited number of delivery systems available (e.g., HMO and PPO only)?

8. Are there other more innovative basic health plan designs that can be considered?

Public Comment Received from Interested Parties

On November 14th, the Commission held a public meeting of interested parties to discuss the issue of a Basic Plan in the small group market and a number of other potential options that would require statutory changes to implement. The meeting was attended by insurance carriers, brokers, employers, consumer advocates, the Maryland Association of Nonprofit Organizations, and state regulators. Written comments were requested to be received by December 3rd.

Carriers and some brokers contended that the creation of a Basic Plan separate from the CSHBP was not necessary and perhaps could be harmful to the small group market. The primary comment was that the modifications that were recently adopted by the Commission to the CSHBP to be effective July 2004, essentially created a "basic" plan. The higher deductibles associated with the PPO delivery system meets the definition of a catastrophic plan as described above; therefore, any alternative basic plan to be developed would be more along the lines of the limited benefit plan. Both carriers and brokers expressed concern that the creation of a limited benefit plan in addition to the CSHBP would lead to risk segmentation in the small group market. The younger, more healthy groups would buy the limited benefit plan (because they would not see the need for the more expansive coverage) and those remaining in the CSHBP pool would see their premiums increase as there would be less healthy people with which to spread the risk. One carrier characterized this as punishing the employer groups who had played by the rules and had been providing coverage for their employees all along under the CSHBP. The overall sentiment was that efforts should be made to encourage healthier groups to purchase the Standard Plan in order to increase the size of the current pool and that making a Basic Plan available would have the opposite effect.

Carriers also expressed concern about a number of issues that are addressed above: that a less comprehensive plan would be unlikely to attract customers; that federally-qualified HMOs could not market a limited benefit plan thus leading to less competition. Carriers also raised the possibility that having two plans in the small group market would actually increase administrative costs because the carrier would have to market two separate products and manage two community-rated pools. One carrier raised the issue of how a limited benefit plan would work in relation to the plan offered under the Maryland Health Insurance Plan (MHIP), the new high-risk pool that uses the same comprehensive benefit plan as required in the small group market. The MHIP product can only be sold to individuals who failed medical underwriting, not employer groups.

The consumer advocates also voiced concern over risk segmentation and, in addition, speculated that having a limited benefit plan would lead to increased underinsurance and that employers and employees would be confused about the level of coverage that they had under the limited benefit plan. A limited benefit plan would give people a sense of health care security that they would not really have.

A lengthy discussion centered on "fixed indemnity" plans which are currently available in Maryland. A number of brokers said that they are already available and becoming increasingly popular and are, in essence, equivalent to a limited benefit plan. Currently, only a very small number of fixed indemnity policies are being sold in Maryland.

Conclusions and Recommendations

By increasing the deductibles in the CSHBP to be effective July 2004, the Commission has already created a **catastrophic plan**. A prudent approach would be to monitor how carriers are responding to this new flexibility and if they are creating consumer-driven products utilizing Health Reimbursement Arrangements and Health Savings Accounts (which are new under the Medicare reform). Monitoring of these plans should include trying to determine whether these products are creating market segmentation.

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With regard to a **limited benefit plan**, it is unclear what effect they would have on the market. Some who claim that the effect will be risk segmentation must believe that a limited benefit would be relatively popular and that employers who currently offer comprehensive coverage will drop it for a less-expensive limited plan. Past experience ten years ago with statutory limited plan indicates this was not the case. Others claim a limited benefit plan will not sell because small employers who buy coverage want comprehensive benefits to compete with benefits offered by large employers in order to retain workers. While this may be true for those employers who offer coverage now, it may not be true for employers with low skilled workers who are easily replaced. Qualitative research performed for the HRSA State Planning Grant indicates that employers with primarily low-wage, high-turnover employees are the types of employers not offering coverage.

The General Assembly could consider permitting the Commission to design a pilot program to test the demand for a limited benefit plan. The parameters of such a plan should be substantially below those of the Standard Plan (e.g., around 50% of the current plan) in order to make it

worthwhile to develop. With regard to the design of a limited benefit plan, it should be noted that most of the model plans evaluated by Mercer were not substantially different than the CSHBP now offered with the exception of pharmacy coverage. By eliminating the pharmacy benefit from the Standard Plan, the Standard Plan would cost about 87% of what it will cost as of July 2004. The only plan which was substantially lower was the limited benefit plan that was in Maryland statute in the early 1990s and later repealed. To achieve the savings estimated by Mercer, the plan would have to be offered through an HMO.

Any plan developed could be offered to employers of low wage workers or to those who have not offered insurance during a certain past period of time (e.g., not offered during the past two years). The Commission would evaluate the success of the limited benefit plan in expanding coverage and whether this product was leading to risk segmentation.

By utilizing a circumscribed pilot program, the potential impact of adverse selection on the pool could be limited by restricting who can buy coverage while reaching out to those employee groups who are likely to be uninsured. The pilot could contain an educational component to assure employees and employers are aware of the difference in the extent of coverage between a limited plan and the comprehensive plan.

IV. Other Potential Changes to the Small Group Market

Other Potential Changes to the Small Group Market

The Commission wanted to explore and present information on some additional potential options to change the small group market that could only be implemented through statutory changes. Some of these are based on legislation introduced during the 2003 session but not enacted and others are based on options that have been put forth in other states, proposed at the federal level, or have been reported in academic literature. These options include: Purchasing Pools, Reinsurance, Tax Credits, and List Billing of Individual Policies.

I. VOLUNTARY PURCHASING POOL OFFERING HEALTH INSURANCE TO SMALL EMPLOYERS AND OTHER GROUPS

Overview

Several states have sponsored health purchasing cooperatives or pools so that small employers, individuals, and potentially large groups can collectively purchase health insurance. A purchasing pool offers the advantage of allowing the pooling of premium contributions from multiple sources and giving employees and individuals a choice of among several health plans rather than a single option. A pool also provides a mechanism for simplified enrollment and administrative efficiency for employers who would like to offer health care coverage but do not have the resources to spare for benefit management. Very small employers are the most likely employers to not offer insurance.

Issues to be Considered in Determining the Desirability of a Purchasing Pool

- Continuity of Care: By providing a single coverage venue that harnesses various contribution sources, the purchasing pool could provide a stable source of coverage (facilitating continuity of care) as changes in family earnings over time affect eligibility and cause people to move among different state, federal and private sources of insurance coverage.

- Mechanism to Combine Premium Sources: The purchasing pool could provide a mechanism to facilitate the combination of multiple financing sources including tax credits, State subsidies, contributions from multiple employers (in the case of part time workers with more than one job), as well as contributions from small employers who are willing to provide some level of contribution but not enough to encourage a participation rate to meet carrier requirements for group coverage.

- Administrative Issues: The pool could reduce employer administrative costs and burdens by playing such purchaser/sponsor roles as negotiating and contracting with health plans, offering workers a choice of competing plans, and resolving coverage problems. Rules for the carriers offering in the pool could also promote greater cost-effectiveness and quality by requiring disease management programs, and incentives for selecting cost-effective care through pricing of cost sharing and co-payments. Many times, certain cost-

sharing arrangements put into place in the small group Standard Plan to encourage appropriate utilization of services are bought away via riders by the employer.

- Employer Requirement for Payroll Deduction: If a requirement were placed on employers to provide an administrative mechanism to help make insurance available by processing payroll deduction for insurance premiums (with no requirement that employers contribute to the costs of insurance premiums), a purchasing pool could serve as the vehicle for enrolling employees and receiving premium contributions. It appears that requiring employers to facilitate employee premium deduction, whether they contributed to the cost of coverage or not, would allow employees to take advantage of the pre-tax deduction of premiums.

- Pool Stability: Insurers will require incentives to sell to this type of group purchasing arrangement. The pool must be large enough to encourage insurers to sell health insurance, and the risk of selling to the participants must be relatively small. The inclusion of a large stable average-risk population to "jump start" the pool would probably be needed to initially achieve economies of scale for risk-pooling and to encourage carriers to participate.

- Cost Savings: Research indicates that substantial premium savings do not result from a purchasing pool unless the rules governing what can be purchased and how it can be priced that apply within the pool are different from the rules governing the rest of the marketplace. However, allowing the purchasing pool to operate under a different set of rules than the general market has led to adverse selection in other purchasing pools (see 'Adverse Selection' below).

- Adverse Selection: The same market rules would likely need to apply both in and out of the pool. Allowing different rules in and out of the pool has lead either to: (1) the pool becoming a high-risk pool, or (2) at the other end of the spectrum, if the pool, through its benefit design and pricing, offers a better deal for the young and healthy, those remaining in the general market will experience higher premiums due to adverse selection. Pools that attract the sick usually need to be subsidized to keep premiums within reach due to the poor health experience of their members. The current rules that address risk selection in the small group market include guaranteed issue and renewal, adjusted community rating and the prohibition of preexisting condition limitations. If different rules were allowed, some mechanism would be needed to mitigate the likely adverse selection.

  In addition, some mechanism would likely be needed to address the potential problem that some healthy individuals will choose to remain uninsured and only the less healthy would join the pool – this mechanism could permit rates to vary depending on the length of time an individual has been uninsured (i.e., "rate-up" by a certain percentage for a certain period of time if the applicant had not been continuously enrolled prior to application). This would discourage employers from waiting until an employee is sick to buy health insurance.

- Reinsurance: In addition, as a "back-end" guard against the possibility that the pool will attract primarily high-cost individuals (see 'Adverse Selection' above), a reinsurance fund could be created to reduce premiums by reducing the amount of risk assumed by any one insurer. Limiting insurers' financial exposure is important for the successful operation of a purchasing pool. In Arizona, insurers are responsible for claims up to $20,000. The State maintains a catastrophic insurance policy for claims exceeding $100,000, and self-insures for claims between $20,000 and $100,000.[1] The Healthy New York program also utilizes a reinsurance pool to alleviate the potential risk to any one carrier and to assist in reducing premiums by shifting some of the risk from the participating carriers to the State.

- Portability: A key benefit of a purchasing pool is that it provides portability across carriers without the medical underwriting requirements that currently exist in the individual market when an individual wants to change carriers because of physician availability, cost, quality or other concerns. In addition, this portability would apply if an employee changed employers; the employee could remain with the same carrier regardless of whether offered by the new employer or not.

- Role for Brokers/Agents: According to the literature on currently-existing purchasing pools, it is essential to preserve the role of brokers and agents in order to encourage them to assist in the recruitment of pool participants – in some states, a certain level of commission has been guaranteed to brokers and agents.

- Solvency: Insolvency among self-insured group purchasing pools has recently increased.[2] In some states, the solvency and reserve requirements are less strict for the pools than insurers. This has led to thousands of consumers nationwide having to pay millions of dollars in unpaid medical claims.[3] The solvency and reserve requirements for this type of purchasing pool should be such that the risk of insolvency is small. A state's guaranty association may not cover consumers' claims should a pool become insolvent. A public-private partnership could enable the state to establish solvency and reserve requirements that would significantly lessen the risk of a future insolvency.

- Implementation Issues: A purchasing pool consisting of small and large employers, state employees, the self-employed, individuals and/or local government employees may need to be implemented incrementally. The viability of such a pool could be tested through a pilot or demonstration project involving very small employer groups (under 10) and one large group such as the State employees.

Questions to be Addressed

A number of questions were posed when the issue brief on purchasing pools was released for public comment.

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[1] Mila Kofman, "Group Purchasing Arrangements: Issues for States," State Coverage Initiatives, Issue Brief, Vol. IV, No. 3, April 2003.
[2] Ibid.
[3] Ibid.

1. Should a purchasing pool begin by targeting certain hard-to-reach groups (i.e., very small employers) and then phase in other populations (larger groups, individuals, etc.)?

2. Should the same rules apply both in and out of the purchasing pool? The literature indicates that different rules seem to lead to adverse risk selection. If those currently purchasing in the non-group market were allowed to buy in the pool, how can the fact that different rules currently apply to the non-group market and the small group market be addressed?

3. Should there be a requirement that carriers participate? Should there be a limit to how many plans can participate? What should be the role of the pool administrators in qualifying carriers to participate?

4. Should employers have the option of buying in or out of the pool? Or only through the pool?

Public Comment Received from Interested Parties

On November 14th, the Commission held a public meeting of interested parties to discuss the desirability of a purchasing pool in the small group market and a number of other potential options that would require statutory changes to implement. The meeting was attended by insurance carriers, brokers, employers, consumer advocates, the Maryland Association of Nonprofit Organizations, and state regulators. Written comments were requested to be received by December 3rd.

Comments from carriers noted the potential and likely difficulties in administration of a purchasing pool especially surrounding the issue of collecting and processing the premiums and the lag time in payment from the pool. It was also noted that a purchasing pool could increase administrative costs as the operating expenses of the pool would have to be paid and, currently, these costs are borne by the carrier but spread out over its entire book of business. These administrative activities would still be needed by the carrier for its other products so the activities would be duplicated. Another carrier suggested that, while there could be administrative savings for employers, it would add to the carrier's administrative costs which would then be passed back to the employer.

The general sentiment was that the small group market reforms and the current community rating requirements are equivalent to having a purchasing pool and that by allowing another separate purchasing pool, the current pool would be diluted. There was a concern about adverse selection between those receiving benefits within the pool and those who remain outside the pool.

There was disagreement by the carriers that the smallest groups are not being targeted; they state that the average size of the employer group they cover is seven lives.

HealthCare for All, while they endorsed the idea of a larger risk pool, felt that health care expansion could be better accomplished through the adoption of their proposal.

II. REINSURANCE

Overview

"The inability to predict a person's medical costs constitutes the largest source of risk for carriers." [4] Reinsurance is an alternative mechanism for spreading risk among insurers that does not involve screening out high risk applicants and referring them to a distinct pool.[5] The essence of this approach is that either the state or a mandatory pooling of carriers would take on most of the risk (cost) of paying for the most expensive cases, making it possible for insurers to offer coverage at lower rates, which should induce more employers to offer coverage. The reinsurance approach limits a given insurer's losses on any individual enrollee or aggregate losses on all enrollees because part of the insurance risk is transferred to another insurer or insurers (or the state).[6,7] Reducing the risk of very high costs for carriers might also create an environment where there are more incentives to participate in the market and reduce the occurrence of insurers employing mechanisms that either: (1) rate enrollees based on their perceived risk (although Maryland's small group market laws already limit carriers' ability to do this)[8], or (2) avoid covering certain populations (e.g., very small employers with 2-10 employees and the self-employed). Even with reinsurance, carriers would retain an incentive to manage every enrollee's care and costs[9] since they would still bear the responsibility for most medical expenses (but not for most catastrophic expenses associated with serious accidents or life-threatening illnesses).

Several states have implemented reinsurance mechanisms in their small group and/or individual health insurance markets. Examples of state reinsurance programs are listed below.

Arizona. Arizona established a reinsurance fund to provide protection against future losses for insurers offering coverage to small employers through the Healthcare Group of Arizona (HCG, which was set up as a separate organization within the state's Medicaid program). In 1999, legislation appropriated $8 million from tobacco tax revenue for FY 1999-2000 and $8 million of the tobacco settlement funds for FY 2000-2001 and each year thereafter to constitute a reinsurance fund to cover large claims and reimburse health plans for their losses.[10] Funding was guaranteed through June 2001. An assessment on all health insurers to fund a reinsurance pool was considered, but was widely opposed by the insurance industry and ultimately rejected.[11]

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[4] Swartz K. Healthy New York: Making Insurance More Affordable for Low-Income Workers. The Commonwealth Fund. November 2001.
[5] Merlis M. "Public Subsidies and Private Markets: Coverage Expansions in the Current Insurance Environment." Kaiser Project on Incremental Health Reform. October 1999.
[6] Ibid.
[7] NAHU. Glossary. Accessed online at www.nahu.org, 15 May 2003.
[8] Swartz K. "Government as reinsurer for very-high-cost persons in the non-group health insurance markets." *Health Affairs*. Suppl. W380-W382. 23 October 2002.
[9] Ibid.
[10] Silow-Carroll S, Waldman EK, Meyer JA. Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs. The Commonwealth Fund. February 2001.
[11] Ibid.

From its inception, HCG purchased reinsurance from a commercial insurer, with participating plans contributing premiums for the reinsurance. Health plans incurred major losses with this approach. The state then opted to self-insure using the $8 million annual appropriation for claims between $20,000 and $100,000 and to buy formal reinsurance for catastrophic claims of $100,000 and above. This approach encourages health plans to better manage low- to normal-risk enrollees and protects them against the more expensive outliers.[12]

New Mexico. New Mexico created the New Mexico Health Insurance Alliance (NMHIA) in 1994 to improve health insurance access for small businesses, the self-employed, and individuals. In this program, risk is managed through reinsurance and shared among virtually all health insurance carriers in the state. NMHIA withholds a reinsurance premium from all premiums for small employers, amounting up to 5% in the first year of coverage and up to 10% in renewal years. The reinsurance fund pays an insurer the amount by which the incurred claims and reinsurance premiums exceed 85% of earned premiums each year. A loss subsidy takes effect if losses exceed the reinsurance fund's resources.[13] Despite the risk-sharing mechanisms introduced in New Mexico, participating carriers have generally considered NMHIA business to be unprofitable.[14]

New York. The Healthy New York program, which was created to increase health insurance coverage in small group and individual markets by making it more affordable, has a reinsurance mechanism. At the inception of this program, the State of New York acted as a reinsurer by subsidizing up to 90% of the costs of enrollees with annual claims between $30,000 and $100,000, implicitly subsidizing the premium by removing much of the insurers' risk of high-cost claims.[15] Carriers paid all of the costs below $30,000 and also above $100,000 and for 10 percent of costs between $30,000-$100,000. It is estimated that approximately 1 percent of the insured population has medical care expenses over $30,000 per year.[16]

In June 2003, Healthy New York revised the reinsurance mechanism by lowering the attachment points (e.g., the level of medical costs at which reinsurance goes into effect).[17] The current range of costs that are subject to reinsurance is between $5,000 and $75,000. Officials at Healthy New York estimate that, by lowering these attachment points, premiums have decreased by 17 percent.

Maryland. During the 2003 legislative session, the *Maryland Health Insurance Reform Act-Modifications- Health Reimbursement Account Plan- Reinsurance Pool*[18] bill was introduced. This bill, which did not pass, proposed repealing provisions of existing law relating to the Maryland Small Employer Health Reinsurance Pool and establishing a new Maryland Small Group Reinsurance Pool requiring membership of carriers who sell in the small group market in the pool and authorizing each member to cede risk to the pool. The bill was not enacted. Carriers are not currently obligated to cede risk to the Maryland Small Employer Health Reinsurance

[12] Ibid.
[13] Ibid.
[14] Silow-Carroll S, Waldman EK, Meyer JA. Expanding Employment-Based Health Coverage.
[15] Swartz K. Healthy New York.
[16] Ibid.
[17] Personal communication with Healthy New York program. 25 April 2003.
[18] House Bill 785 / Senate Bill 609, 2003.

Pool, and some carriers have indicated that they instead purchase reinsurance for all of their lines of business as a whole with a reinsurance carrier or reinsure through another one of the divisions in their own company.

Issues to be Considered in Determining the Feasibility of Providing a Reinsurance Mechanism

- Effect on Premiums and Access: Providing reinsurance can reduce premiums.[19] Because individual carriers would not need to purchase as much reinsurance as they currently do, these costs would be lowered so that premiums could be reduced and more uninsured people could subsequently be induced to purchase coverage.[20]

- Competition: A reinsurance mechanism could serve to maintain or increase insurer participation in the small group market, thus enhancing price competition. Since insurers' risk of paying for very high costs would be reduced, smaller carriers could more easily afford to enter and stay in the market.

- Cost Control Incentive Maintained: Reinsurance can include incentives for carriers to restrain health care costs since carriers would still be responsible for covering a certain proportion of costs after reinsurance starts[21] and, if structured like Healthy New York, all costs that exceed the reinsurance cap. The proportion covered by a carrier could also be structured using a sliding scale which decreases as expenses increase (i.e., 50% for claims between $30,000-$50,000; 25% for claims between $50,000-$150,000, and 0% for claims above $150,000).

- State Subsidy: To lower costs of coverage significantly - which is necessary to induce a substantial number of uninsured small employers to offer coverage - and if the state were to act as the reinsurer, the state subsidy would have to be large.

- Some Carrier Risk: In the Healthy New York program, carriers are not totally protected if claims for high-cost enrollees exceed the available reinsurance funds.[22] In addition, reinsurance does not eliminate the risk that an individual carrier may have a disproportionate share of claims above the maximum attachment point. In the event that this occurs, carriers might request higher premiums to recoup their losses.[23]

- Affect on Carrier's Own Management of Reinsurance: There is some evidence that large carriers reinsure themselves through subsidiaries of their own company so that a public pool would reduce profits in their own reinsurance line of business.

[19] Swartz K. Markets for individual health insurance: Can we make them work with incentives to purchase insurance? The Commonwealth Fund. December 2000.
[20] Swartz K. "Government as reinsurer.
[21] Swartz K. Healthy New York.
[22] Ibid.
[23] Ibid.

- Limited Experience: Limited data exist on the experiences that states have had with reinsurance mechanisms, which makes it difficult to determine the optimal method for implementing this option.

Questions to be Addressed

A number of questions were posed when the issue brief on the feasibility of providing a reinsurance mechanism was released for public comment.

1. Should the reinsuring entity be the State itself (or reinsurance purchased by the State) or a State-charted corporation administered and financed by health insurers (including, potentially, all carriers selling state regulated health insurance plans writing policies for State employees and Medicaid)?

2 If the State subsidizes the pool, how much should it contribute to the pool and what should be the attachment points?

3. What are the potential savings in premiums by having insurers cede risk at certain attachment points?

4. Should reinsurance be linked with a purchasing pool? (See section on Purchasing Pools).

Public Comment Received from Interested Parties

On November 14th, the Commission held a public meeting of interested parties to discuss the issue of providing a reinsurance mechanism in the small group market and a number of other potential options that would require statutory changes to implement. The meeting was attended by insurance carriers, brokers, employers, consumer advocates, the Maryland Association of Nonprofit Organizations, and state regulators. Written comments were requested to be received by December 3rd.

The carriers and a consumer group did not support reinsurance as a means of reducing the cost of health insurance. The carriers believe that private reinsurance, or reinsurance purchased directly by the carrier, is more cost-effective and creates an incentive for carriers to manage care effectively. Private reinsurance is based on a carrier's claims experience, thus encouraging the carrier to manage the care provided to their members through care and disease management programs, as well as the payments to health care providers. The carriers indicated that mandatory reinsurance pools create a disincentive that inevitably leads to less efficient care since higher risks are transferred to the pool. A consumer group commented that the State will take on much of the cost from high risk patients, thus shifting the cost from insurers to their benefit. In addition, a state-mandated reinsurance pool would require state-funding.

A business owner supports the concept of a privately-funded reinsurance pool to encourage more carriers to sell the CSHBP, thus leading to greater competition in the small group market and reduced premiums.

III. TAX CREDITS FOR SMALL EMPLOYERS

Overview

Offering tax credits to help people purchase individual health insurance is a key component of the national debate over how to reduce the number of uninsured Americans.[24] The primary purpose of this approach is to lower the net cost of coverage for those buying health coverage. While tax credits have been offered as a way to assist individuals in purchasing health benefits, another option to increase access to health coverage is to have the State extend a tax credit to certain small employers who offer and subsidize health benefits to employees.

With the tax credit approach, some employers would have the opportunity to receive tax credits to help pay for the cost of offering health insurance to their employees. Reducing health care premium costs in this way could make coverage more affordable for both employers and employees and create an incentive for more small employers to offer health insurance to their employees. To make this approach cost effective, the subsidy would need to be limited to certain employers, such as those employing low-wage workers, working in certain industries, newly offering health coverage, or having a certain level of firm size (i.e., 10 or fewer employees). Employers would also need to be required to pay some reasonable portion of the premium. This option could include provisions to specify the minimum benefits that the insurance would cover: for example, through the currently required Comprehensive Standard Health Benefit Plan or a "basic" plan currently under consideration (see section on Feasibility of a Basic Plan).

Providing small employers with health coverage tax credits has been proposed at the federal and state levels as an option to expand coverage. In 2001 and 2002, for example, several proposals were introduced at the federal level (S.2679 and S.284) to create tax credits for small businesses. One of these options included offering a 30% to 50% tax credit (the percentage would be dependent on the size of the firm, with smaller firms receiving a higher percentage) to help offset the costs of health insurance for small firms with low-wage workers and provide these employers with an incentive to offer health insurance.

At the state level, legislation offering tax credits to offset the cost of health insurance premiums for either small employers or individuals has recently been introduced in **Colorado, Florida, Georgia, Hawaii, Indiana, Maine, Montana, Missouri, New Mexico, New York, Pennsylvania** and **Vermont**.[25] Vermont policymakers have recommended creating a small employer tax credit by providing subsidies directly to employers to help them offer coverage to their workers. Eligibility would be limited to firms that have not provided health coverage for at least the 12 previous months and to firms with an average payroll below the average for small firms in the state.

Another related option is to offer health coverage tax credits to low-income individuals who work for small businesses that either do not contribute to paying for health benefits or do not

[24] Center for Studying Health System Change. The Individual Health Insurance Market: Researchers, Policy Makers Seek Common Ground on Tax Credits for the Uninsured. Issue Brief No. 58. December 2002.
[25] National Conference of State Legislatures. Health Policy Tracking Service Issue Briefs Summary. 1 April 2003. Available online at http://www.ncsl.org/programs/health/healthinsurance.htm.

offer any health coverage options. This would provide assistance to individuals who could otherwise not afford health benefits to buy into their employer-sponsored plan or purchase individual coverage.

It has been suggested that tax credits be linked to some sort of group purchasing pool so as to keep all those being subsidized in a single risk pool.[26] The availability of tax credits only to those who participate in the purchasing pool could act as an impetus to get employers or individuals to participate in the purchasing pool and thus make the market share represented by the pool attractive to carriers. All of the issues related to the creation of a purchasing pool would still need to be addressed (see section on Purchasing Pools).

Issues to be Considered in Determining the Feasibility of Offering Tax Credits

- Effect on Access: Tax credits could expand access to health insurance in the small group market by decreasing the amount that employers or individuals would pay for health insurance, thereby enabling more people to purchase health coverage (many for the first time).[27,28]

- Use of Current System: As contrasted with an approach that involves setting up separate subsidy programs for the uninsured, this approach builds on employer-based insurance systems, depends on market forces, and creates incentives for employers to make private coverage available to their employees. Nearly 60% of Maryland's uninsured are employed adults and 77% of Maryland's non-elderly uninsured live in families with one or more full-time workers.

  The development of new government programs would not be required because existing administrative procedures of the tax system could be used for tax credit initiatives.

- Increased Participation of Low-Risk Individuals: The anticipated increased participation of younger and healthier employees, who might be employed in low-wage businesses, in the small group market could cause premiums for all employees in this market to decrease.

- Size of Tax Credit is Critical: The success of a tax credit depends on the size of the credit. Many employers who do not offer coverage are small, marginal firms that hire primarily low-wage employees. Since these businesses may not generate significant profits, they may not incur much of a tax liability. These employers might not experience sufficient benefits from a tax credit and might not participate unless the tax credit was refundable and quite large. It has been estimated that even a 30 percent reduction in

[26] Sally Trude and Paul B. Ginsburg, "Tax Credits and Purchasing Pools: Will this Marriage Work?" Center for Studying Health System Change. Issue Brief No. 36. April 2001.
[27] *Ibid.*
[28] Pollitz K, Sorian R. Ensuring health security: Is the individual market ready for prime time? *Health Affairs*. Suppl. W372-W376. 23 October 2002.

premiums would cause only 15 percent of small employers currently not offering health insurance to decide to offer it.[29]

- Possible Limited Impact: Even after receiving tax credits, small employers who help subsidize their employees' coverage would still have to pay a significant portion of health insurance premiums from their own funds; this amount might be more than firms with marginal profits can afford. Moreover, low-wage employees might prefer to have any increased compensation in the form of higher wages. Therefore, this approach might have a limited impact on improving coverage of the uninsured.

- Refundable and Advanceable: Credits that are available only at the time of tax filing would not make insurance coverage affordable for employers who have insufficient monthly income to pay the insurance premiums during the year. An advanceable tax credit could address this concern, but generates administrative difficulties.

- Impact on State Budget: Because tax credits would need to be large to be effective, this approach could have a significant budgetary impact in the form of foregone tax revenues.

- Response of Employers Currently Providing Coverage: There is a possibility that some employers already providing coverage would take advantage of the tax subsidy and cut back on their contribution toward employee health insurance premiums. To prevent this, the credit could be limited to firms not previously providing coverage, though this creates equity problems among employers and may create gaps in insurance coverage.

- Administrative Concerns: Some employers might not be willing to assume any additional administrative responsibilities associated with receiving tax credits, such as potentially complicated applications and rigorous eligibility standards.

- Does Not Address Underlying Causes of Cost Increases: Tax credit options do not address the underlying causes of increasing small group market premiums, such as higher per person utilization of health care services, the loosening of managed care cost-control measures, and new medical technologies and higher-cost new-generation pharmaceuticals.

Questions to be Addressed

A number of questions were posed when the issue brief on the feasibility of offering tax credits was released for public comment.

1. How much does a tax credit need to reimburse to convince employers to offer and employees to buy insurance? How much in lost tax revenue can the State afford?

[29] James D. Reschovosky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

2. What population should be targeted for a tax credit?

3. If the tax credit were refundable and advanceable, how can administrative issues be addressed?

4. Should a tax credit be linked to an authorized purchasing pool?

Public Comment Received from Interested Parties

On November 14th, the Commission held a public meeting of interested parties to discuss the issue of offering tax credits in the small group market and a number of other potential options that would require statutory changes to implement. The meeting was attended by insurance carriers, brokers, employers, consumer advocates, the Maryland Association of Nonprofit Organizations, and state regulators. Written comments were requested to be received by December 3rd.

The respondents support the concept of tax credits as a general incentive to small employers to offer health insurance to their employees; however, several posed concerns related to the source of funding and the level of participation. One carrier proposed that tax credits are a "way of increasing affordability and accessibility in the small group market." However, a business owner indicated that tax credits act as a subsidy and therefore, may, in fact, lead to higher health insurance charges only to exacerbate the problem of rising health insurance premiums. Consumer groups are concerned that funding for tax credits may be redirected from State programs such as Medicaid or federally qualified health centers, and that the size of a tax credit is critical to the take-up rate of small businesses.

IV. LIST BILLING

Overview

"List billing" is a billing option that allows premiums for a group of individual health coverage policies to be paid by a single payor, such as an employer. Each individual owns his or her policy and pays 100 percent of the cost of their policy, while their employer or other third party facilitates the payment of the premiums. Therefore, list billing is not the same as employer-sponsored health insurance since participating employers simply submit the premiums for an individual employee's own plan.[30] Employers deduct the health insurance premium from the participating employee's paycheck on a pre-tax basis. The supporters of this type of arrangement maintain that it is designed for employees who are ineligible for employer-sponsored coverage.[31]

In 2003, legislation introduced in **Maryland** would have permitted the offering of individual health coverage policies through a small employer to an eligible employee on a pre-tax, list-billing basis.[32] However, the policies could only be offered if: 1) the small employer has not been providing or offering a health benefit plan to its employees during the prior six-month period and 2) the employee has not been eligible for a health benefit plan during the prior six-month period. In addition, the legislation would have eliminated the reference to Section 125 of the Internal Revenue Code[33] from Maryland's small group market reform law. It has been suggested that removing the reference to Section 125 from the small group statute will allow carriers to offer individual policies to small employers without the IRS considering those policies to be group policies subject to all group policy requirements. However, more information is needed on the full effect of removing this section. The bill was withdrawn on March 22, 2003.

Golden Rule Insurance Company is one insurer that offers health insurance through list billing.[34] The company, which sells health coverage policies, solicits employers to offer individual coverage to employees or their families who are not eligible for an employer-sponsored plan. The employees, or their spouses and/or dependents, apply for coverage through Golden Rule. Golden Rule then notifies employers of the applying employees who are eligible for the company's coverage and bills the premiums to the employer on a monthly basis. The employer, in turn, deducts the premium amount that was billed from the payroll of the participating

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[30] Golden Rule Insurance Company. *List Bill Instructions and Forms*.

[31] Ineligible employees include, for example, those who are not an eligible class of employee to receive employer-sponsored coverage as specified by the employer (e.g., only management-level employees are eligible to receive coverage), part-time employees, employees of companies that do not provide or cannot afford to offer health coverage, or spouses or dependents of eligible employees of an employer who does not offer spousal or dependent coverage.

[32] House Bill 1029 (2003).

[33] Section 125 of the Internal Revenue Code, enacted by Congress in 1978, allows companies to give their employees the opportunity to pay for benefits on a pre-tax basis. Pre-tax benefits lower payroll-related taxes for both the employer and employees. According to the IRS, Code section 125 makes it possible for employers to offer their employees a choice between cash salary and a variety of nontaxable benefits (qualified benefits). Qualified benefits include health care, vision and dental care, group-term life insurance, disability, dependent care, adoption assistance and certain other benefits.

[34] Golden Rule Insurance Company currently provides a list billing option in the following states: Arizona, Arkansas, Georgia, Illinois, Indiana, Iowa, Michigan, Mississippi, Missouri, Nebraska, Ohio, Pennsylvania, South Carolina, Texas, Virginia, and West Virginia.

employee, but cannot pay any portion of the premium or reimburse the employee for any amount of the premium. However, the employer can set up a Section 125 cafeteria plan, which would allow for employer deduction of the premiums prior to taxing the employee.[35]

According to the Department of Labor, carriers may sell individuals policies within a group setting under a 'safe harbor' provision of the Employee Retirement, Income and Security Administration (ERISA) regulations.[36] Under this provision, the employer or employee organizations "are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer." In addition, no contributions are made by the employer on behalf of the employee, participation in the program is voluntary, and the employer does not receive any consideration (such as cash) in connection with the program. Under this scenario, a group type plan is not considered an "employee welfare benefit plan" and "welfare plan" under ERISA (not a group plan), and therefore, not subject to HIPAA regulations.

In many states, such as **Arizona**, the billing arrangement is allowed only because there is nothing in statute that either permits or prohibits it. In **Indiana** list billing is allowed; however, policies are considered to be group health plans if an employer is sponsoring or endorsing them in any way. Other states, such as **Georgia**, have assumed a very strict interpretation of the federal HIPAA guidelines and do not allow list billing in a workplace setting.

One of the major concerns about list billing individual policies through employers is that the practice is simply a way for carriers to circumvent small group market reforms, and possibly negatively impact the reforms. In **Ohio**, for example, the Department of Insurance has stated that many carriers refuse to list bill because they believe it makes non-compliance with small group market laws too easy. The National Association of Health Underwriters (NAHU), which represents health insurance agents, often receives calls from its members regarding list billing. The organization's interpretation of this practice is that if carriers list bill, the policies must be HIPAA-compliant (e.g., the policies must be issued on a guaranteed issue basis and there cannot be pre-existing condition limitations greater than six months) if they are payroll deducted, whether or not the payroll deduction is done on a pre-tax basis.[37]

Issues to be Considered in Determining the Allowance of List Billing

- Access to Insurance Benefits: These arrangements could facilitate health insurance enrollment of individuals who are employed but are not eligible for employer-sponsored health coverage or whose employers do not offer health coverage. List billing could also increase health coverage rates of spouses and dependents of employees.

- Effect on Premium: If list billing is offered on a pre-tax basis, the cost of premiums for employees who participate will be more affordable than if they purchased the coverage on their own in the individual market.

[35] Golden Rule Insurance Company. "Elimination of Reference to Section 125 in Small Group Reform Law." Presented to State of Maryland, 2003.
[36] Code of Federal Regulations, 29CFP2501.3.
[37] MHCC communication with the NAHU. August 2003.

- Lack of Information: Information on list billing is difficult to obtain, and there is little evidence to suggest that this issue has been widely studied, if at all. The states that were surveyed by the Maryland Health Care Commission (MHCC) do not collect data on list billing, and no peer-reviewed literature could be identified by the Commission. Therefore, it is challenging to conclusively determine if there are any impacts, either positive or negative, of these list billing arrangements.

- Effect on Small Group Market: Some states do not view list billing as a problem for the small group market. For example, one state surveyed stated that the effect of list billing on the small group market is "immaterial because it is only for those not eligible for group coverage."[38]

  The impact of list billing on small group market reforms remains unclear. As some states have indicated, it is possible that insurance carriers could use this practice as a mechanism to circumvent the reforms. It is also unclear what the effect would be of removing the reference to IRS Code Section 125 from the small group statute.

- ERISA Concerns: While Federal regulations permit the selling of individual policies through employers (ERISA "safe harbor" provision), the employer cannot 'endorse' the insurer's plan. The definition of employer 'endorsement' is vague. A Department of Labor advisory opinion stated that an employer who states that the employer or employer organization is 'enthusiastic' about a program is considered an endorsement. It is unclear what is not considered endorsing a plan, and also how it would be enforced.

- Reliance on Third Party to Submit Premium: If individuals choose to participate in a list billing arrangement, they must trust and rely on the third party to ensure that their premiums are actually paid and submitted on time so that their coverage is maintained. For example, Golden Rule states that it "has no obligation to guarantee coverage or any other liability in the event that coverage lapses due to the Third Party's failure to submit payment by the due date." In addition, any refunds related to an individual employee's policy are credited to the third party list bill account, rather than directly to the applicant.

- Need for Clear Understanding of What is Being Purchased: The policies offered are for individual coverage, so employers will need to clearly communicate to their employees that this type of coverage may differ substantially from employer, or group, coverage. For example, these policies will be medically underwritten and are not offered on a guaranteed issue basis, and employees should understand such characteristics of these policies before purchasing coverage.

- Breadth of Effect: According to Golden Rule, the number of individuals who select health insurance through the list billing arrangement is a few hundred – a minimal number of individuals affected by this arrangement.

[38] MHCC communication with Arkansas Department of Insurance. July 2003.

Questions to be Addressed

A number of questions were posed when the issue brief on the allowance of list billing was released for public comment.

1. What is the effect of removing the reference to Section 125 plans in current law?

2. If the effect of this option is minimal in terms of how many additional individuals will be provided coverage, in the face of uncertainty of its effect on the small group market, should this option be permitted?

Public Comment Received from Interested Parties

On November 14th, the Commission held a public meeting of interested parties to discuss the issue of list billing in the small group market and a number of other potential options that would require statutory changes to implement. The meeting was attended by insurance carriers, brokers, employers, consumer advocates, the Maryland Association of Nonprofit Organizations, and state regulators. Written comments were requested to be received by December 3rd.

All respondents, with the exception of a single carrier, who sells in the individual market, oppose list billing as a means of increasing the number of individuals with health insurance. Those carriers who do not support list billing have indicated that it segregates the market, pulling the 'healthy lives' out of the small group, and, therefore, will lead to higher costs in the CSHBP. Small employers with younger and healthier employees will have an incentive to not accept group coverage, and, instead, encourage their employees to purchase individual policies through the list billing practice. Many carriers stated that individual insurance policies offered on a list billing basis are not offered the same protections as that in the small group, such as guaranteed issue, community rating, and no medical underwriting. In addition, list billing may add to administrative costs of carriers (by selling individual policies) that will in turn lead to higher costs. A consumer group stated that list billing "gives employees the illusion of employer-based health security when none really exists."

In contrast, one carrier believes that individual policies offered through a small employer on a list billing basis can be affordable compared to the CSHBP, are void of participation requirements, and can be tailored to meet the needs of the individuals and their family. In addition, this carrier believes that certain 'protections' (i.e., an employee cannot be eligible for group coverage during the previous six month period) discourage small employers from circumventing the small group market. This carrier sells individual policies through list billing in other states and claims that this practice does not harm the small group market.